Specifying Fevers: Positioning Malaya's Health Lobbies (1867-1941)

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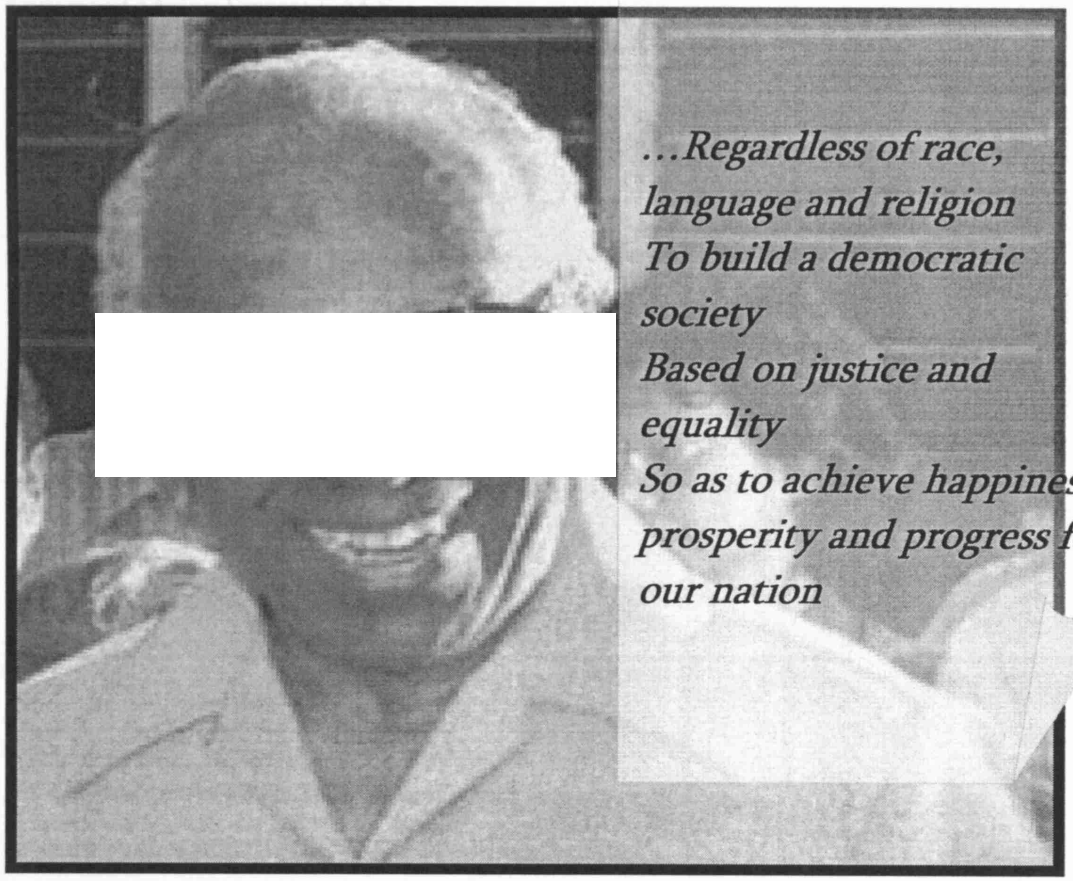
This dissertation explores the roles of interest groups in the provision of medical facilities and the shaping of public policies in colonial Malaya. Business associations, medical missionaries, temperance movements and international health organisations were instrumental in financing and establishing medical facilities, as well as promoting public health issues and particular infectious diseases as flagships to define and platform larger socio-political agendas. Among the organisations included were the local merchant and plantation bodies, Anti-Opium Societies and social hygiene based organisations, the League of Nations and the Rockefeller Foundation. Their activities were situated within the contexts of health in the urban centres, plantation estates and rural hinterlands. In addition, these groups were visible in addressing social problems manifested through opium addiction and venereal diseases, and the crisis during the 1918 influenza pandemic.

Collectively, these lobbies served to broaden the appreciation of the multi-layered interactions between health and society. The appropriation of healing functions by these non-medical organisations revealed a more pluralistic discourse on medicine beyond that of the medical practitioners or public health officials. Operating simultaneously at the local, regional and international contexts, the transnational networks of these organisations open up the possibilities of a more globalised perspective of health and medicine. The doctoral thesis hopes to historicise the phenomenon of non-government organisations in colonial Malaya, and to present new insights of the medical and socio-political contexts in which they operated.



In Memory

S. Rajaratnam (1915-2006)

Abbreviations

Association for Moral and Social Hygiene: A.M.S.H
British Social Hygiene Council: B.S.H.C
Colonial Office: C.O.
Federated Malay States: F.M.S
Federated Malay States Annual Report: F.M.S.A.R
International Health Board: I.H.B.
Malay Mail: M.M.
Malaya Tribune: M.T.
Nanyang Siang Pao: N.Y.S.P.
Penang Gazette: P.G.
Planters' Association of Malaya: P.A.M
Public Records Office: PRO
Rockefeller Archives Centre: R.A.C.
Rockefeller Foundation: R.F.
Rubber Growers' Association: R.G.A.
Singapore Free Press: S.F.P.
Straits Echo: S.E.
Straits Settlements: S.S.
Straits Settlements Annual Report: S.S.A.R
Straits Settlements Legislative Council Proceedings: S.S.L.C.P.
Straits Settlements Medical Report: S.S.M.R.
Straits Times: S.T.
Times of Malaya: T.M.
Unfederated Malay States: U.F.M.S
Women's Library: W.L.

Contents

Preface: Writing New Histories under the Banyan Tree

对现实的领悟能加强人们的思想，能够消除恐怖并指示他们如何为这个纷乱的世界带来理智与秩序，这便是文学写作者所应付的责任. 合他的写作目的，应该是提高社会认识对现实生活的各种问题的自觉性和理解力，并指出他们如何将人类的感情生活和创作才能加以融合，这样我们便可能提高我们对事物的评价，丰富我们的理解力，以及加强我们对自己本身和我们社会的控制.这便是马来亚文学的任务.[1]

龙素夫·伊萨.

Since 1867, the Thong Chai ("Benefit to All" in Mandarin) Medical Hall, an ethnic Chinese charity, has been dispensing free medical aid to the destitute in Singapore. Generously supported by the ethnic Chinese merchant community, the institution also served as a hub for traditional Chinese medical practices, headquarters for guilds, as well as a venue for public meetings and other cultural events. One of its premises, built in 1892, was subsequently gazetted as a national monument in 1973 in recognition of the medical hall's historical and architectural significance.[2] In 1999, the interior of the building was converted into a disco-wine bar. However short-lived, the oriental kitsch, meant to provide a "dose of energy," incited a howl of protest at the crass gentrification.[3] Beneath such debates are the struggles to retain a social and urban heritage in the face of the rapidly changing postcolonial city-state under the pervasive custodianship of the People's Action Party (PAP) government.

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[1] 龙素夫·伊萨，*马来亚作家会议开幕致词*，*马来亚作家会议报告会*(新加坡:新加坡国家学语文巨, 1962), 页 10. "In the midst of real anxieties, he is able to strengthen the thoughts of the people, to dispel their horrors and show them a rational way; this is the responsibility of the intellectual. His purpose of writing should be to sharpen social consciousness towards the vicissitudes of life, and channel their emotions constructively. In this way, we can improve our judgement of matters, enrich our discretionary abilities, and reinforce our self-understanding as well as our influence on society. This is the role of Malayan intellectuals."-Long Su Fu, quoted from Report of the meeting of Malayan Writer's Association in 1962 (Text translated by author).

[2] See also: Singapore Thong Chai Medical Institution. *Singapore Thong Chai Medical Institution 135th anniversary commemorative magazine, 1867-2002* (Singapore: Singapore Thong Chai Medical Institution, 1995).

[3] *Straits Times*(Henceforth known as *S.T.*) 10 July 1999, 30 August 1999.

Since gaining self-government in 1959, the PAP had intensified the administrative machinery in moulding social relationships and behaviours through a combination of public exhortations accompanied by calibrated system of incentives and penalties. In spite of the rapid progress from "Third World to First", it has often been observed that this development has either come at an expense of, or resulting in the decline of the influence of civil society in Singapore. In effect, the state has been analogous of the extensive canopy of the banyan tree choking the undergrowth from sunlight. With alternative centres of powers in trade unions, newspapers, interests groups and community organisations actively suppressed, tacitly incorporated or just losing their relevance, social movements in Singapore became seemingly peripheralised. Aside from the scaling back of services, civil society groups also lost their initiative in framing discourses and debates as the state agendas of development and stability gained primacy. What has happened is not only gradual political de-sensitisation, but also a selective amnesia of the historicity of civil society, often portrayed dismissively by national leaders as being politically in its infant stages.

Echoing Ernest Gellner's observation of the Communist Bloc in the 1980s, Chua Beng Huat feels that the Singapore state has "strongly centralised all aspects of life, and where a single political-economic-ideological hierarchy tolerated no rivals and one single vision defined not only truth, but also personal rectitude."[4] He believes that many Singaporeans would readily see their country implicated in this description in spite of the republic's highly successful economic development. Accordingly, the term civil society has been accorded "great political value" in Singapore.[5] Thus, more than just another "Western project," the study of medicine and civil society in the region becomes a search for a space; one, according to David Schak and Wayne Hudson, that encompass a "zone of interaction, cooperation and compromise."[6] Although not specifically devoted to the study of Thong Chai Medical Hall, the debates surrounding its gentrification reflects a broader urgency in cultivating a more informed historical appreciation of the role of health lobbies in the republic.

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[4] Chua Beng Huat. "Non-Transformative Politics: Civil Society in Singapore", in David Schak and Wayne Hudson (eds). *Civil Society in Asia* (United Kingdom: Ashgate, 2003) p. 20.
[5] Ibid.
[6] Schak and Hudson (eds). *Civil Society in Asia*. p. 2.

In *Deconstructing History*, Alun Munslow poses the fundamental question: "Just as it is impossible to have a narrative without a narrator, we cannot have a history without a historian. What is the role of the historian in recreating the past?"[7] The motivation of embarking on this project arises from the space engendered by the contestations of the health lobbies within colonial civil society. The emphasis of these elements on the right to check the excesses and deficiencies of government institutions deserves to be retold. In particular, the moral dilemmas raised by the abolitionists on the indignities imposed on prostitutes by the Contagious Diseases Ordinance becomes crucial in indicating how such debates have been sidelined even though the issues have not entirely disappeared.[8] This intention, I feel, highlights the pivotal emotional difference between my roles as an Asian/local historian seeking ownership of the past I call home, as against those who under the postcolonial auspicious of "writing back", are turning a physical entity into a "diluted and abstract exercise"[9]

A more ambitious motive, on my part, is to steer the intellectual directions of the humanities and social sciences in Singapore away from the narratives of the post-1959 state. Major scholarly works on contemporary Singapore have been primarily devoted to theorising the ethos and logic of the PAP government.[10] While this has been inevitable given the government's exceptionally comprehensive reach over society, it

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[7] Alun Munslow. *Deconstructing History* (London: Routledge, 1997).

[8] One issue of concern has been the selective re-introduction of the Ordinance involving the mandatory examination of prostitutes and female foreign domestic workers in a belief by the public health authorities that these expedient measures would contain the spread of venereal diseases. The measures have recently been extended to pregnant women as part of the move to make preliminary detection on HIV infected babies. There are considerations to cast the net wider to male homosexuals who have also been blamed by the National leaders for a spike in Aids. The issues of the unjust, stigmatising and patriarchal implications of this ordinance raised by the temperance movements in colonial Malaya against the compulsory medical examination of prostitutes serves to historcise this apparently forgotten debates. See: Liew Kai Khiun. "Those Earnest and Pernicious Ladies: International Health Movements and the Feminisation of Singapore's Colonial Legacy", Derek Heng (ed) *New Insights to Singapore's History: Perspectives from Young and Emerging Historians* (Singapore: National Library Board, forthcoming).

[9] Ooi Keebeng. "Three-Tiered Social Darwinism in Malaysian Ethnographic History", *Southeast Asian Studies*, 41.2 (September 2003): 162-79.p.167. For debates between the Eurocentric against Asian-centric histories by Asian and Western historians of Southeast Asia, see: Thongchai Winichakul. "Writing at the Intertices: Southeast Asian Historians and Postnational Histories in Southeast Asia", Abu Talib Ahmad and Tan Liok Ee (eds). *New Terrains in Southeast Asian History* (Singapore University Press, 2003) pp. 3-29, John Smail. "On the Possibility of an Autonomous History of Modern Southeast Asia", Laurie Seares (ed). *Autonomous Histories: Essays in Honour of John Smail* (USA: University of Wisconsin, 1993) pp. 39-70.

[10] The two authoritative works on state-civil society relations in Singapore are Michael Hill and Lian Kwen Fee. *The Politics of Nation-Building and Citizenship in Singapore* (London: Routlege, 1995) and Chua Beng Huat. *Communitarian Ideology and Democracy in Singapore* (London: Routlege, 1995). See also: Gillian Koh, Ooi Giok-Ling (eds). *State Society Relations in Singapore* (Singapore: Institute of Policy Studies, 2000).

nevertheless reinforces officialdom as the major, if not sole mover of history, with the people reduced to either passive spectators or lemmings. Observing the overarching hegemony of the Singapore state, sociologist John Clammer pondered "how, when and where genuinely popular countervailing forces" would emerge amongst students, youth, women, intellectuals..." In his pessimistic conclusion, Clammer feels that "it is barely possible today to write on urban social movements in Singapore; my hope is that it will not be long before it is possible.[11]

This dissertation represents both my personal involvement and broader exploration of civil society in Singapore. Since embarking on my academic journey in 2000, I have been trying to view social forces from different historical and contemporary perspectives through labour movements NGOs, media and cultural expressions. It is perhaps of Himani Bannerji's excerpt below that most describes my academic mission most accurately where:

> Keeping in mind the possibilities of change and criticism, breaks and fissures that exist even within the scope of our disciplinarian hermeneutics, we have to face the fact that the impetus for radical intellectual criticisms come from the struggles in our lives, and from the world in which we live. Our being in the world and the struggles that surround us mirror each other. From social movements that create both history and possibilities of critical knowledge from memories and experiences politicised as organisations and identities of people come our inspiration to write new histories.[12]

Similarly, I am also taking up the challenge by Lenore Lyons and James Gomez to observers of civil society in Singapore to come out from the facade of "objectivity" to state their "politics of location."[13] Both of them have lamented not only the apparently parochialised and valorised portrayals of NGO, but also questioned the intellectual integrity of Singapore based academics.[14] I hope that this project will produce the "critical knowledge" to sufficiently respond to their charges by providing a more historically informed appreciation of the participation of civil society in Singapore.

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[11] John Clammer. *Race and State in Independent Singapore, 1965-1990: The Cultural Politics of Pluralism in a Multiethnic Society* (Singapore: Ashgate, 1998) p. 279.
[12] Himani Bannerji. "Politics and the Writing of History" in Ruth Pierson and Nupur Chaudhuri (eds). *Nation, Empire and Colony; Historicising Gender and Race*. p.297 (USA: Indiana University Press, 1998). P. 297.
[13] Lenore Lyons and James Gomez. "Moving Beyond the OB Markers: Rethinking the Space of Civil Society in Singapore". *Sojourn: Journal of Social Issues in Southeast Asia*. 20:2 (October 2005): 119-32. p. 120.
[14] Ibid. p.121-123.

It has been a priceless privilege to pursue the highest level of education without being burdened significantly by the interventions of life. I am grateful to have a stable family who has been supporting my pursuits in life, many with little monetary returns. In spite of my routine complaints, my soulmate Kelly has been persistently standing by me in the cold winters and hot summers. Of course, a word of thanks for my prospective in laws, Auntie Lisa and Uncle Richard for treating me like a son. Aside from them, there are also wonderful friends who are always there for me in London and Singapore. The staff and students of the Wellcome Trust Centre have indeed been crucial in making my stay in London generally memorable. To begin with, I am truly indebted to the invaluable guidance of my principal supervisor, Dr Sanjoy Bhattacharya ever since our first meeting in Singapore in 2002. He has generously shared his experiences and knowledge with me and has staunchly supported my research work.

In spite of their overwhelming workload, the doors of Professor Harold Cook and Alan Shiel have always been opened for me every matter, be it sorting out tuition fees or writing referee reports. It is through their firm but quiet and caring support that the Centre is a place I am proud to be associated with. There are of course others in the Euston Road that should be acknowledged here, namely: Dr Michael Neve, Professor Anne Hardy, Dr Vivienne Lo, Dr Ma Ka Wen, Kim Ki-Heung, Debra Scallan, Alan Yasbely, Vera Man, Adam Wilkinson, Bettina, Emma Ford, Carol Bowen, and not forgetting the lovely coffee, biscuits and touching oral history accounts from Joan. I have also learnt considerably from my fellow PhD candidates including, Nandini, Candice, Danny, An, Leela, Rohan, Abey, Akinobo, Noberto, Theresa, Richard, Katrina, Karen etc. Among the postgraduate fraternity, a special note of thanks to Stephen Casper for his insightful comments into my dissertation.

Without my grounding in the History Department of the National University of Singapore, I do not think I will be given the slightest opportunity to reach that far, literally. A big thanks to Associate Professor Tan Tai Yong for his tireless encouragement throughout all these years. Despite assuming increasing administrative duties over the years, he has always been personally forthcoming. In addition, there are faculty staff who have patiently nurtured my intellectual development since my undergraduate days a decade ago. They include: Associate Professor Huang Jianli,

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Introduction: Prioritising Fictions, Hierarchicalising Diseases

A fiction about soft or easy deaths is part of the mythology of most diseases that are not considered shameful.[1]

Susan Sontag

It has been remarked that the conception of the tears of the Archangel Michael creating countless cherubim in his likeness to control the rain and guard the fruits and plants of the earth exhibits a pantheistic tendency. The same may be said of the diagnosis of the Kelantan medicine-man, who finds a hundred and ninety demons for smallpox, each operating on a selected part of the body, His Lordship Buzz on the ear, His Lordship Peg on the joints, and so on. In Patani there are elders and midwives who believe that all evil "spirits were really one, pervading the whole world, only called by different names according to the environment in which the universal spirit of evil was considered for the moment. . . . As one old man expressed it, ' It may be hot here and at Mecca at the same time, and the spirit is the same.' He went on to explain that the spirit could break itself into one hundred and ninety parts, and that the great medicine-man was the person who could cause it to do this and could keep all the different parts under his control. "[2]

From: Shaman, Saiva and Sufi XI_ Magician and Mystic

The Tears of Archangel Michael: Specifying Fevers

Writing on Malay folk medicine, colonial surgeon Dr A.L. Hoops described its culture of identification of diseases with supernatural elements or *Jins*. Among the spirits of lesser potency were those related to bowel-based diseases while the ghosts of women who died from childbirths were said to be notoriously malevolent. At the top of the hierarchy was smallpox, which its name, *Ketumbohan*, must not even be uttered.[3] Conversely, the European planters in Malaya believed the names of the more terrifying scourges should be loudly propagated as seen in the notices from the Malaria Advisory Board: "MALARIA: The greatest danger to life and health in Malaya; MALARIA: Can be prevented and ought to be prevented."[4]

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[1] http://www.brainyquote.com/quotes/authors/s/susan_sontag.html

[2] http://www.shamana.co.uk/shaman/sss07.htm

[3] Taken from the *Malay Mail* (henceforth: *M.M.*). 14 October 1929. For a more detailed discussion of Malay medical practices, see: Carol Laderman. 'The Limits of Magic', *American Anthropologist*, 99:2, 333-341.

[4] Taken from *The Planter*. Vol XI No. 4. Nov 1930. p.xviii. Handbooks by planting associations ranked malaria as the chief causes of mortality in the colony. This was followed by bowel, lung, skin and venereal diseases, and trailed lastly by "maternal deaths." See: A.N. On and A.N. Other. "Estate Health: A brief Review of essentials", *The Planter* Vol XIII No 2. Sept 1932. p. 32.

In his survey of the medical statistics of British Colonial possessions in 1937, P. Granville Edge metaphorised the list of infectious diseases as a "bewildering series of sanitary experiences as varied as the contents of the witches' cauldron in [Shakespeare's] *Macbeth*."[5] A persistent category that kept appearing was that of "fevers unspecified." This ambiguity aroused from the difficulties in classifying the cause of every death or illness. Yet, the principles and practices of health policies have historically been placed under the microscope by an array of local, regional and international health movements. These groups had not only lobbied for legislative changes, but also provided medical services to contain what they perceived to be the most pressing diseases of the period.

This chapter explores the relevance of health lobbies in broadening the historiographical approaches towards the understanding of medical historiography in general, and also within the context of colonial Malaya. In turn, the study of their activities can help in identifying patterns in which diseases are prioritised along undercurrent ideological anxieties, and medicine used as a tool to mobilise society to address such fears. Moreover, even as these organisations were seemingly specific in their goals, the socio-historical contexts they operated in can provide more insights into the dynamics of state-civil society relationships. The roles of these health lobbies in pioneering the provision of public health services, the extent of their influences on government policies, and the layered social networks engendered will be discussed. A study of these activities in turn, can facilitate a more sensitive appreciation of deployment of the medical discourses by interest groups to establish their social positions as well as the efforts of the governing bodies to co-opt these interests. In the process, bringing up the legacies of these health lobbies in British Malaya will also contribute to the empirical knowledge and conceptual debates surrounding its historiography.

[5] P. Granville Edge. "The Demography of British Colonial Possessions: A Note on the Assembly and Interpretation of Data", in *Journal of the Royal Statistical Society*, Vol.100, 181-231, p. 183.

Social History of Medicine: Mission accomplished?

Essentially, the discourses of medicine and health are reflections of man's attempt to grapple with the fragility of the flesh. In the process, a host of narratives has been generated on the relationship between the sick and the healer in rationalising pain, prolonging life, or postponing death. Collectively, these narratives translate into a more macro imagination of disease and death, health and healing. Imaginations are however also socially contested. In general, this can be witnessed in the struggles between differing medical frameworks, i.e. Court versus Folk, Western against Traditional, Scientific over Alternative etc. These dichotomies are in turn interwoven into more complex socio-historical trends continuously bonding and stratifying societies and civilisations.[6]

At the formal level, the focus on the story of medicine in the modern context has been a triumphant tale of Western science overcoming superstition and diseases. By the 1970s, however, trends pointed to the revision of these assumptions.[7] Disillusionment began to set in with the persistence of infectious diseases, astronomical health costs, elitism of medical practitioners, profiteering pharmaceuticals and uneven distribution of medical resources.[8] More importantly, medicine is increasingly being scrutinised as another mode of social monitoring and regimentation on subjugated bodies, like women, workers and animals.[9] The discourses of health and sickness also serve to reinforce social hierarchies determined by not just the extent of access to medical facilities, but by the coercive public health regimes.[10]

These observations have opened up new perspectives in the study of social relations, particularly in the study of the European colonialism which has commonly assumed to have been established merely on military might. Rather, in calling for a wholly different appreciation, Stuart Hall reminds his readers: "colonisation was never simply external

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[6] See: Waltraud Ernst (ed). *Plural Medicine, Tradition, and Modernity, 1800-2000* (London, New York: Routledge, 2002), Linda H. Connor and Geoffrey Samuel (eds). *Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian societies* (Westport, CT : Bergin & Garvey, 2000).

[7] See: John Ehrenreich, (ed). *The Cultural Crisis of Modern Medicine* (London, NewYork: Monthly Review Press, 1978).

[8] James Le Fanu. *The Rise and Fall of Modern Medicine* (London: Little Brown, 1999).

[9] See: Michel Foucault. *The Birth of the Clinic: An Archaeology of Medical Perception* / translated from the French by A.M.Sheridan Smith (London: Tavistock, 1973).

[10] See:Peter Freund, Meredith McGuire, Linda Podhurst. *Health, Illness, and the Social Body: A Critical Sociology* (Upper Saddle River, N.J. : Prentice Hall, c2003).

to the societies of the imperial metropolis. It was always inscribed deeply within them, as it became indelibly inscribed in the cultures of the colonised."[11] In underpinning the importance of the socio-cultural dimensions of colonial discourses or postcolonial studies, Ania Loomba stresses:

[...]a new way of thinking in which cultural, intellectual, economic or political processes are seen to work together in the formation, perpetuation and dismantling of colonialism. [These studies] seeks to widen the scope of studies of colonialism by examining the intersection of ideas and institutions, knowledge and power. [12]

Beginning from literary studies, the critique of cultural hegemony in Western modernity has extended to the field of medicine, which has otherwise been casually assumed as a politically odourless and clinically beneficial tool. As one of the earliest (and perhaps almost forgotten) detractors was Franz Fanon's denunciations of the involvement of colonial psychiatric institutions in the systematic subjugation and infantilisation of the native subjects.[13] It was only two decades after Fanon's landmark denunciation of colonial psychiatry in the 1960s that historians began to concretise their understanding of the power relationship within the medical institutions of the colonial state. In the late 1980s, Roy Macleod and Milton Lewis outline these issues as:

If by imperialism we mean the extension of international systems of domination...it is clear that medicine has a place in this definition. In the history of medicine, the concept of imperialism has come to serve as much as a tool of apologetics as a domain of scientific enquiry. If medicine, viewed as technology helps illuminate methods by which European expansion took place, then medicine, as a system of practice, suggests how, within knowable limits, its objectives could be achieved[...]If the history of imperialism in medicine can be taken to comprise the expansion of medical attitudes, beliefs and practices to non-medical domains, then the history of medicine in empire refers to the complementary history of medical regimes as participants in the expansion and consolidation of political rule.[14]

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[11] Stuart Hall. "When was the Postcolonial?", in Iain Chambers and Lidia Curti (eds). *The Postcolonial Question* (London, New York: Routledge, 1996) p.246.
[12] Ania Loomba. *Colonialism/Postcolonialism* (London & New York: Routledge, 1998) p.54.
[13] See: Franz Fanon. *Black Skin, White Mask.* transl. Charles Lam Markmann (New York, Grove Press, 1967). Hanafy Youssef and Salah A. Fadl, "Frantz Fanon and Political Psychiatry", *History of psychiatry*. Vol. 7, pt. 4:28 (Dec. 1996): 525-32. H.F. Butts. " Franz Fanon's Contribution to Psychartry: The Psychology of Colonialism and Racism" *Journal of the National Medical Association* (New York). Vol. 71 (1979) 1015-1018.
[14] Roy Macleod and Milton Lewis (eds). *Disease, Medicine and Empire; Perspective on Western Medicine and the experience of European Expansion* (London, New York: 1988) p.2.

Expanding on their arguments, David Arnold feels: "In part, the history of colonial medicine, and of epidemic diseases with which it was so closely entwined, serves to illustrate the more general nature of colonial power and knowledge and to illuminate its hegemonic as well as its coercive processes."[15] Thus, while the authority of medical science in the West was rooted in the promise of modernity, its meanings were transformed in the colonial context as rationalisations and justifications of hegemony.[16] As such, Megan Vaughan expresses the need of "finding a new language" to challenge the power of the biomedical languages that continues to retain a strong and even at times, "imprisoning influence" over postcolonial studies.[17]

In the process of effecting a critical revision of the perspective of colonial medicine, the postwar generation from Fanon to Vaughan have also created an intellectual orthodoxy. Highly inspired by their critiques, subsequent scholars dutifully applied these theories to their case studies. Inevitably, this has created rumblings of overkill among medical historians who felt that the job has been completed once the "naked truth" is exposed. This sentiment towards the task of revealing the "social" in medicine has also been expressed in the wider fraternity of medical historians, a project which gained momentum since the 1970s.[18] Roger Cooter describes such feelings as:

> Clearly, in the pluralized medical marketplace there is not one but multiple sources of authority, and the idea of the passive patient is noticeably passé...According to Charles Rosenberg in 1989, enough had been written to convince all but the most moronic that "every aspect of medicine's history is necessarily "social" whether acted out in laboratory, library, or the bedside. Since this "all is social" theme had been the historiographical mission of the context-celebrating subdiscipline since the mid-1970s, there is no need to go on about it. Mission accomplished.[19]

Sharing the same doubts, Warwick Anderson laments that even the critical history of colonial medicine has led to "multiplying national histories" whereby "every member of

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[15] David Arnold. *Colonising the Body; State Medicine and Epidemic Disease in 19th Century India* (University of California Press, 1993) pp.8-9.
[16] Kavita Sivaramakrishnan. *Old Potions, New Bottles: Recasting Indigenous Medicine in Colonial Punjab, 1850-1945* (New Delhi: Orient Longman: 2006) p.3.
[17] Megan Vaughan. *Curing their ills. Colonial Power and African Illness* (UK, Cambridge, Polity Press, 1991) p.205
[18] John Burnham. *What is Medical History?* (UK, USA: Polity Press, 2005) pp. 135-42.
[19] Roger Cooter. 'Framing" the End of the Social History of Medicine' in Frank Huisman and John Hareley Warner (eds). *Locating Medical History; Their Stories and their Meanings* (London, Baltimore: The Johns Hopkins University Press, 2004) pp. 313-20.

the United Nations will have its own history of germ theories and public health, its own history of medicine. However, he observes that these histories seem "disappointingly enclosed and self-sufficient...[and with] frequently a predictable tone and teleology in these proliferating, meticulously situated social histories of medicine."[20] An identical critique comes from Marion Wallace's work on colonial health in Southwest Africa. She argues that most research in this area have been placed between the Gramscian notions of consensual form of hegemony and the Foucauldian disciplinary mechanisms of control. But, she warns that an overuse of the ideas of the exercise of power on bodies tends to dehumanise the real subject, and, in turn, "re-inscribing the colonised as non-human, someone with a body, but no brain or soul."[21] On the similar apparent repetition in the larger critique of colonialism, Sumit Sarkar points out: "A reiteration of the already said: for it needs to be emphasised that the bulk of the history written by modern Indian historians has been nationalist and anti-colonial in content, at times obsessively so. Criticism of Western cultural domination is likewise nothing particularly novel."[22]

Even as they are frustrated with the limitations, these historians have not offered any alternatives. Cooter's premature announcement of "mission accomplished" does not address continued marginalisation of especially non-Western medical traditions and narratives that has yet to be sufficiently documented and theorised. More importantly, it creates a false impression and complacency on the supposed universality of medical historiography founded upon more Eurocentric premises. In other words, there is a need to distinguish the limitations of the historian's human imagination from the potentials in which historiography of medicine has to offer. In this respect, I see three potential missing links within the study of medical history, namely, in the hierarchy, political mobilisation and transnationality of medicine.

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[20] Warwick Anderson. "Postcolonial Histories of Medicine." Ibid. pp.285-306

[21] Marion Wallace. *Health, Power and Politics in Windhoek, Namibia*, 1915-1945 (Switzerland: P. Schlettwein Publishing. 2002) p. 13.

[22] Sumit Sarkar. *Writing Social History* (Oxford University Press. 1997) p. 104.

Evaluating Health

Every manifestation of sickness, disease and health has conjured different narratives and histories. In the words of George Rosen:

> In considering health as a social value, the point of interest would be to know how this value has been defined by various social groups, the nature of the desires and expectations of different groups in respect to health, and the extent to which these ends are achieved or frustrated. Naturally, this involves an understanding of the hierarchy of values in our society, and of the place which health as a value occupies in different social classes. It will be immediately apparent that knowledge of this type has fundamental implications for such field as medical care, nutrition and health education.[23]

While this undertaking has been important in providing the jigsaws in the puzzle of the socio-historical study of medicine, it has also been responsible in the discipline's fragmentation.

According to Arnold, "disease has in itself no meaning: it is only a micro-organism. It acquires meaning and significance from its human context, from the way in which it infiltrates the lives of people, from the reaction it provokes, and from the manner in which it gives expression to cultural and political values."[24]A largely isolated attempt to "de-fragment" this trend has been made by Susan Sontag's *Diseases and Metaphors,* where she contrasted the expression of fear of AIDS against that of cancer through the metaphors.[25] Putting the body as a social entity, she explained how the degree of aversion of the disabled or diseased body could be conjured with different societal implications from sympathy to fear and shame. As Suzanne and James Hatty put it: "the body is not only the agency through which the social environment is created, but it is also the surface (or text) upon which is inscribed the range of historical, social, and cultural discourses which prevail in a society."[26] This interest reflects the influence of Michel Foucault in demonstrating the route of power through the knowledge of, "The

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[23] George Rosen. *From Medical Police to Social Medicine: Essays on the History of Health Care* (New York: Science History Publication, 1976) pp. 116-7.
Ibid. p. 117.
[24]Quoted in: Paul Slack and Terence Ranger. "Introduction", in Ranger and Slack (eds). *Epidemics and ideas: Essays on the Historical Perception of Pestilence* (Cambridge: Cambridge University Press, 1992) p.10.
[25] Susan Sontag. *Aids and its Metaphors* (London: Penguin Books, 1989).
[26] Suzanne E. Hatty and James Hatty. *The Disordered Body: Epidemic Disease and Cultural Transformation* (USA: State University of New York Press, 1999) p. 7. See also: Geoffrey Bowker and Susan Star. *Sorting it Out; Classification and its Consequences* (USA: The MIT Press, 2000).

body [becomes] as a story or a text, that can be read and interpreted as we do literary texts, the sick body, the well body, the gendered body, the narrative body-all make their appearance."[27] Nonetheless, the actual human agencies involved in conjuring these spectres, and their rallying cries to exorcise them are not adequately theorised. As this dissertation will reveal, the fears aroused in the minds of the merchant may be radically different from that of a priest or doctor, man or woman. As Paul Unschuld reflects:

> A system of healthcare concepts and practices is plausible and acceptable when its ideas concerning the emergence, nature and appropriate treatment of illness correspond to the socio-political ideas concerning the emergence, nature and appropriate management of social crisis adhered to by a social group or by an entire society.[28]

Collectively, the works of these theorists on the body have largely been set in more contemporary contexts. However insightful perspectives offered on the social contours of the body, these studies are generally remained poorly historicized. Following Charles Rosenberg's landmark *Framing Diseases,* there have been attempts by historians to historicise the cultural definitions and representations of bodily afflictions.[29] At a certain level, they should be credited for opening up crucial avenues for the literary and cultural angles of medicine and diseases.[30] Nonetheless, being concentrated on the cultural politics of representation, these studies have yet to concretely inform readers on the "realpolitik" of interest articulation and aggregation. In this respect, I feel this project offers the opportunity in the case of British Malaya, to not only "frame" diseases along Rosenberg's line, but also to politically hierarchise the degree of fear invested in them. It is also through this hierarchy that the significance of health and diseases as politically contested grounds by different players, state and society, can be made more evident.

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[27] Gert Brieger. "Bodies and Borders: A new Cultural History of Medicine". *Perspectives in Biology and Medicine* 47.3 (2004): 402-21. p.409. See also: George Sebastian Rousseau, with Miranda Gill, David Haycock, Malte Herwig (eds). *Framing and Imagining Disease in Cultural History* (New York ; Basingstoke : Palgrave Macmillan, 2003).

[28] Paul U. Unschuld. "Epistemological issues and changing legitimation: Traditional Chinese Medicine in the 20th century" in Charles Leslie and Allan Young (eds). *Paths to Asian Medical Knowledge* (University of California Press, 1984) p.45

[29] Charles Rosenberg. *Framing Disease: Illness, Society, and History* (USA: Rutgers University Press, 1992).

[30] See Brieger. "Bodies and Borders: A New Cultural History of Medicine". *Perspective in Biology and Medicine.* 402-21.

Mobilising and Internationalising Health: The Non-Government Sector

As governments assumed wider responsibilities in public health since the 19th century, societies became increasing regarded as recipients of state hospitals and contagious disease legislations.[31] This interpretation however, suggests a one-way imposition of a monolithic state over a passive or reactive populace as well as a non-existent civil society. Pertaining to the significance of the latter, Paul Weindling notes:

> The voluntary sector has maintained a vital role at the local, national and international levels. Its flexibility and ethos of care and of altruistic dedication have to be set against disadvantages of uneven resource distribution and paternalist ideologies, as well as a stigmatising tendency in the direction of 'cringe or starve.' Universalist concepts of human rights extended into the sphere of entitlement to welfare, and supranationalist ideals have given international organisations important roles in pioneering innovations, monitoring conditions and organising assistance. [32]

Placing the health movements within a larger historical context would reinforce the contemporary understanding of the issues concerning the seemingly globalising activities of contemporary NGOs, organisations described as New Social Movements.[33] Frederick Cooper in his study on the anti-slavery movement during the colonial period saw them as:

> The "transnational issue networks" within, across, and against empires have a particular importance that belies the empire-conquest/community-resistance framework. The anti-slavery movement was the model; starting among British protestants in the late 18th century, crossing the Atlantic to become an Anglo-American movement, invigorated by the conviction and symbolic importance of ex slaves linked to slave colonies by this complex social movement showed that empire can be a space of moral discourse.[34]

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[31] Michel Foucault viewed the evolution of modern social medicine along three categories They are: the state led bureaucratisation of medical practice in the German model, the improvement made by the French on the politico-medical schema of the quarantine system of the late Middle Ages, and, the English counterpart of promoting a population of politically docile but economically productive bodies. James D. Faubion (ed). *Michel Foucault. Power. Essential Works of Foucault. 1954-84.* Translated by Robert Hurley (London: Allen Lane, 1994), p. 134-56.

[32] Paul Weindling (ed). *International Health Organisations and Movements* (Cambridge University Press, 1995), pp. 1-2

[33] The notions of a "global civil society" has been increasingly popular in the scholarly circles to describe an apparently a new socio-cultural phenomenon and a promising progressive force. Gideon Baker and David Chandler. *Global Civil Society* (London: Routledge, 2005).

[34] Frederick Cooper. *Colonialism in Question: Theory, knowledge, History* (University of California Press, 2005) pp.199-200.

It is the possibilities opened by the transnational networks engendered by the health movements that deserve more attention for the challenges it poses towards national historiographies; a challenge laid out by Antoinette Burton on ":...[Whether] is it possible to challenge the dichotomies of "home" and "away" that underwrite national and imperial histories; to merge centre and periphery and posit and imaginative and material space where metropole and colony emerge simultaneously, rather than a teleological and imperialised sequence?" [35] Peter Waterman observes that the globalising effects of social movements create a situation where the activities of such organisations would place themselves in multiple positions, in local-to-global space or vice-versa.[36]

The international reach of mainly contemporary Western NGOs is a manifestation of a wider "globalisation" paradigm impressing on scholars a need to call for what Stephen Howe describes, "to reappraise the global systems of the past."[37] Nevertheless, as seen by the excerpts of Weindling and Cooper, there seems to be a tendency towards celebrating these "Social Movements" as heroic counter-narratives to oppressive state apparatus.[38] While the philanthropic and humanitarian motives of these organisations have been widely extolled, their paternalistic cultures were also brought under greater critical attention. The underlying assumptions of these enterprises have been premised upon the notions of the backwardness and helplessness of their clients.[39] Inevitably, the programmes of the US Peace Corps, Rockefeller Foundation and GreenPeace have been accused of reinforcing American neo-colonialism.[40] Hence, given the mixed legacies of these non-state agencies, the notions of an idealised and undifferentiated "social

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[35] Antoinette Burton (ed). *After the Imperial Turn; Thinking with and through the Nation* (USA, Duke University Press, 2003) p. 11.

[36] Peter Waterman. "Social Movements, Local Places and Globalised Spaces: Implications for Globalisation from Below", in Barry Gills (ed). *Globalisation and the Politics of Resistance* (New York: Palgrave, 2000),p. 137.

[37] Quoted in Stuart Ward's "Transcending the Nation: A Global Imperial History?", in Antoinette Burton (ed). *After the Imperial Turn; Thinking with and through the Nation* (USA, Duke University Press, 2003) p. 53.

[38] Robert Lauer defines social movements as "group of people who are organised for, ideologically motivated by, and committed to a purpose which implements some form of personal or social change; who are actively engaged in the recruitment of others; and whose influence is spreading in opposition to the established order within which it originated." Robert H. Lauer (ed). *Social Movements and Social Change* (Southern Illinois University Press: Carbondale and Edwardsville, 1976).

[39] Rupert Emerson. "Colonialism", in *Journal of Contemporary* History, 4(1): 3-16. p. 13.

[40] For a more updated discussion see: Paul Greenough and Anna Lowenhaupt Tsing (eds). *Nature in the Global South; Environmental projects in South and Southeast Asia* (New Delhi: Orient Longman: 2003)

movement" becomes problematic when applied to the historical context, particularly within the context of colonialism.

Comprising activists, community and commercial representatives, these groups entered the colonial possessions was once dominated by traders, soldiers and administrators, internationalising their involvement alongside European imperial expansion. A crucial outcome was the re-mapping of political geographies based on affiliations to social ideologies of health and medicine. Armed with the faith of triumphant biomedicine,[41] organisations and activists regarded medicine as not just curing individual diseases, but reshaping entire civilisations.

Generally, these organisations have been understood within the contexts of civil society involvement.[42] However, this highly Eurocentric and undifferentiated term becomes limited in explaining more complex transnational contexts in which these health lobbies operated. To begin with, the organisations featured here existed simultaneously in varied localities, possessing both diffused and intersecting networks. With diverse agendas, they played out concurrently the roles of providing community services, monitoring and challenging officialdom, but also strengthening the hegemonic structures. Business interests, socio-cultural associations, religious bodies, the media, philanthropists and abolitionists, are commonly identified as autonomous agents of civil society. Nonetheless, it is important that they should not be perceived as an uniformed force acting in concert with the singular purpose of democraticising and pluralizing society from the grip of the party-state.

Through the various players to be elaborated, another purpose of this project is to locate the roles and representations of medicine within the particularities of colonial civil society in British Malaya. In other words, which sector of colonial civil society did health lobbies appeal to, how did issues of public health and medicine provide avenues for the expansion of public participation, and how inclusive or "public" were such participations? Kavita Sivaramakrishnan attributes the enduring indigenous medical traditions in colonial Punjab to the financial, intellectual and political support of the

[41] J.N. Hays. *The Burden of Diseases. Epidemics and Human Response in Western History* (New Jersey. London: Rutger University Press. 1998) pp. 246-7.
[42] Krishnan Kumar. "Civil Society: An Inquiry into the Usefullness of an Historical Term", *The British Journal of Sociology* .44.3 (September 1993): 375-95.

emerging Indian urban bourgeois rather than the conventional explanations of the limitations of the British administrators in imposing their version of modern medicine.[43] It is suspected here her study touches only a tip of the iceberg of such unique historical social dynamics of civil society involvement in health lobbies outside the Western hemisphere. Thus, it is not that these elements were absent, but their legacies were rendered invisible by scholars blinkered by the assumptions of a lack of mediating agencies along modern European patterns in these supposedly feudal colonial societies.

The "discovery" of colonial civil societies is therefore a crucial insertion to the general appreciation of the dynamics of colonialism. To be further discussed in the next chapter, the subsequent use of the term "colonial civil society" here refers to groups with the ability to funnel resources into medical provisions or/and utilise medical knowledge as rallying grounds for broader social agendas. Among the case studies to be included here are the European and Chinese merchant groups and plantation associations, the International Health Board (IHB) of the Rockefeller Foundation, the colonial English language newspapers, women medical missions and temperance groups pertaining to opium addiction and venereal diseases. It will be shown in the following chapters of how this grasp of medical power/knowledge mirrored the extent of influence that different health lobbies possessed within the strata of colonial civil society.

Hidden Histories beyond the Colonial Office

In general, historical writings of Malaya have followed changing trends in the general historiography of medicine.[44] As they established their presence in the territory, the British took greater anthropological interests in the medical traditions and practices of the indigenous and migrant populations. However well documented, these studies made by what Nicolas Tarling classifies as "scholar-officials",[45] became instrumental in exoticising and antiquarianising non-Western narratives against supposedly rationalised

[43] Sivaramakrishnan. *Old Potions, New Bottles.* pp.32-52.

[44] For details on the development of Malayan historiography, see: Edwin Lee. "The Historiography of Singapore", Basant Kapur (ed). *Singapore Studies: Critical Surveys of the Humanities and Social Sciences* (Singapore University Press, 1986) pp. 1-32.. and Khoo Kay Kim. "Local Historians and the Writing of Malaysian History", Anthony Reid and David Marr (eds). *Perception of the Past in Southeast Asia* (Singapore: Einemann Educational Books, 1979) pp. 299-311.

[45] Nicolas Tarling. *Historians and Southeast Asian History* (Auckland: New Zealand Asian Institute, 2000) pp.56-9.

ethos of modern public health.[46] At the same time, the "progressivist" claims of modern medicine were glorified as part of the myth of Empire. As part of the celebration of the centenary of the founding of Singapore, G.E. Brooke, who was also a government medical official, wrote about the "progress" of the colonial medical services in the colony from its humble beginnings.[47]

With the accelerated development of national institutions from the postcolonial era in the 1960s, the "whiggish teleos" highlighted the narrative of the linear advancements of the postcolonial state against its former masters.[48] At the same time, the historiography of medicine was also defined along contemporary national boundaries. These trends are visible in Lee Yong Kiat's *Medical History of Singapore (1819-1873).*[49] Focused predominantly on the development of the fledging public health services in a supposedly highly diseased new colony, Lee was more focused on describing the inadequacies of the colonial medical services in dealing with diseases and sickness. Treating Singapore as a separate entity from the hinterland, the publication of his works coincided with the growing prosperity of the city-state and the rapid modernisation of public health infrastructure.[50] The historiographical traditions apparently started by

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[46] John Gimlette. *Malay Poisons and Charms Cures* (London: J.A. Churchill Press, 1923), and *A Dictionary of Malayan Medicine,* edited and completed by H. W. Thomson, with a foreword by Malcolm Watson (Kuala Lumpur: Oxford University Press, 1971). David Hooper. *On Chinese Medicine :Drugs of Chinese Pharmacies in Malaya* . The Gardens Bulletin Straits Settlements, Vol. 1, No. 1, 1929. I. H. Burkill and Mohamed Haniff. *Malay Village Medicine* (Singapore: Singapore Botanic Gardens, 1930). For a more comprehensive list of articles and books written on medicine in Colonial Malaya, see: C.E. Wurtzburg. "An Index to all Journals of the Straits Branch of the Royal Asiatic Society", *Journal of the Malayan Branch of the Royal Asiatic Society* Volume 5, Part 4, (1927): 1-191. pp. 39-44, and, Beda Lim. "Malaya: A Background Historiography", *Journal of the Malayan Branch of the Royal Asiatic Society.* Volume 35 Parts 1-2 (1962): 1-199. pp.20-47.

[47] G.E. Brooke GE. "Medical Work and Institutions": Makepeace W, Brooke GE, Braddell RSJ, editors. *One Hundred Years of Singapore.* Vol 1.pp. 487-519, See also: O.F. Conoley. "Medical Work in Malaya", *Malaya Medical Journal.* Vol.VI, 1931: 42-46.

[48] Wee. W.L. "Our Island Story. Economic Development and the National Narrative in Singapore" , Ahmad and Tan (eds) *New Terrains in Southeast Asian History*, pp.142-6.

[49] Lee Yong Kiat. *Medical History of Early Singapore.* (Tokyo : Southeast Asian Medical Information Center, 1978)

[50] See: Khoo Keng Hock. *Medical Services in the Straits Settlements.* 1867-1905. (Hons Thesis: Singapore. University of Malaya: 1955); Susheila Vethavanam. *Medical Work in the Malay States of Perak, Selangor, Negri Sembilan and Pahang, 1874-1914* (Hons Thesis: University of Malaya: 1957) Julia Meredith Raja Segaran. *Development of the Medical Services in the Malay States 1881-1911:From Death Houses to Hospitals.* (M.A.Thesis:Malaysia:.Fakulti Sastera & Sains Sosial. Universiti Malaya, 1982); Rosana bte Md. Jani. *Hospitals and the Healthcare System in Singapore 1819-1926,* (Hon Thesis: National University of Singapore, 1989). Enid M. Wylie. *Economic Change and Diseases in Malaya c.1820-1920: A Study in Human Ecology* (PhD Thesis: *USA:* Giffith University. 1993).

Brooke and reinforced by Lee, continues to be lionised by Singapore's elite medical fraternity.[51]

A more comprehensive picture of the British medical services came in Phua Khai Hong's doctoral thesis on the *History of the Health Services in Malaya.*[52] His institutional survey was however superseded by more subtle analysis of power relations in individualised subjects of municipal, estate, mental health, opium and venereal diseases.[53] These revisionists accounts have probably been influenced by a greater awareness of the "social" component in medical historiography in the early 1980s.[54] However, it was in Lenore Manderson's *Sickness and the State*, that an ambitious attempt to address a multiplicity of themes of imposition of, and resistance to colonial medicine was made. In her opinion, until this publication, the history of "tropical medicine" in Malaya was "nothing more than part of the tradition of focusing on heroic effort and defeat of the pathogens."[55]

Nonetheless, writings on the history of British Malaya in general, not just in medicine have, and continues to be, heavily reliant on the vast collection of archival materials of official documents. This covers government documents entailing annual reports, commissions of inquiries, advisory boards and correspondences. Although regarded as authoritative sources, these records are limited largely to the views of the bureaucracy. Anthony Milner comments such an approach leads to a culture of conservatism even among non-British historians who decipher the past through the "refractions of the

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[51] J.S. Cheah. "History of Medicine in Singapore". *Singapore Medical Journal*, 38(6), 1997.

[52] Phua Kai Hong. *The Development of Health Services in Malaya and Singapore 1867-1960* (London: University of London Library, 1990).

[53] Ng Beng Yeong. *Till the break of Day: A History of Mental Health Services in Singapore, 1841-1993* (Singapore: Singapore University Press, 2001). See also: Lum Lai Meng. *Mental Health in British Malaya.* Hons Thesis (Singapore: National University of Singapore, 1995). For works on urban health, opium addiction and venereal diseases in Malaya, see Chapters 2,3,6 and 7 respectively.

[54] From 6-8 May 1983, an exploratory conference titled: "Disease, Drugs, Death: Their History in Modern Southeast Asia", was held at Australian National University. Several of the papers presented were subsequently collated in the landmark publication. *Death and Disease in Southeast Asia*, several years later. Norman Owen (ed) *Death and Disease in Southeast Asia: Explorations in Social, Medical and Demographic History* (Singapore: Oxford University Press, 1987). It was only recently that a conference on a similar theme on the region. "First International Conference on Southeast Asia, 9-10 January 2006, Centre for Khmer Studies," was held in Siem Reap , Cambodia.

[55] Lenore Manderson. *Sickness and the State: Health and Illness in Colonial Malaya, 1870-1940* (Cambridge: Cambridge University Press, 1996) p. 13. See also: Hairudin bin Harun. *Medicine and Imperialism: A study of the British colonial Medical Establishment, Health Policy and Medical Research in the Malay Peninsula, 1786-1918* (London : University of London Library, 1990).

[colonial] bureaucratic machinery."[56] As a result: "In this historical tradition, therefore, British power in Malaya is given a monolithic character and such a perception of the colonial structure has necessarily had an impact on the way individual events were interpreted."[57] This meant that the history in British Malaya was seen to have been driven by British administrators, hence obscuring the seemingly less visible social determinants within colonial society.

This is where the study of health lobbies in British Malaya is important in broadening the appreciation of the roles of an otherwise less evident colonial civil society in shaping the medical discourses and expanding the public health infrastructure. These activities, in addition to the international and regional networks of these organisations will provide a more critical insight into how health was being socially mobilised, prioritised, internationalised and mediated in British Malaya. Last but not least, such explorations will also facilitate a more critical historicisation of civil society's position in the colony, which portrayal is still confined to anecdotal and institutional perspectives.[58]

Positioning History and the Historian: A Note on the Sources

Rather than just a collection of "facts", Ann Laura Stoler regards colonial archives as "both sites of the imaginary and institutions that fashioned histories as they concealed, revealed and reproduced the power of the state."[59] In this respect, official records permit a glimpse into not just official mindsets. Thomas Richards describes how the administrative core of the British Empire was built around knowledge-producing institutions like universities and museums as well as data intensive bureaucracies. [60] This "recording and documentation of empire became a way to bolster feelings of

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[56] Anthony C. Milner. "Colonial Records History: British Malaya", *Modern Asian Studies*, 21:4 (1987):773-92. pp. 782-3. See also: Milner. "Inventing Politics: The case of Malaysia", *Past and Present*, No. 32 (Aug, 1991), 104-129.

[57] Ibid. 779.

[58] See: E.Kay Gillis. *Civil Society and British Power in Singapore* (Singapore: Talisman, 2005). Carl Trocki. *Singapore: Wealth, Power and the Culture of Control* (London: Routledge, 2005). Walter Makepeace, Gilbert E. Brooke, Roland St. J. Braddell. *One Hundred Years of Singapore: Being some account of the Capital of the Straits Settlements from its Foundation by Sir Stamford Raffles on the 6th February 1819 to the 6th February 1919* (London: Murray Press, 1921).

[59] Ann Laura Stoler. "Colonial Archives and the Arts of Governance". *Archived Science*. 2(2002): 87-109.p. 97.

[60] Thomas Richards. *The Imperial Archives: Knowledge Fantasy and Empire* (London, New York: Verso, 1993) p. 4.

colonial power, even in the absence of full control of vast geographic territories."[61] Concerns over public health, including accounts of the relationship between the colonial administration and health lobbies, were prominently featured in these records as part of the efforts of colonial officials to make sense of the territories under their charge.

Despite the wealth of materials left behind by the colonial state, such information in itself does not fully portray the past. Although these archives have been more readily accessible, it is only through the agency of the historians rather than the historical players that reproduces Stoler's and Richards's impressions of state and empire. In an attempt to reduce the reliance on official records from the Colonial Office of the Public Record Office (PRO), this project aims to explore the subject through the use of archival materials from non-government organisations. The search has been a transnational undertaking involving primary materials from the United Kingdom, the United States of America, Switzerland and Singapore.[62] Among relevant collections in Britain outside the PRO are the records of the activities of the social hygiene groups in the Wellcome and Women Libraries and the Singapore Diocese in the Lambeth Palace Library. In addition, complete collections of the Rubber Grower's Association (RGA) and scattered primary materials on Singapore based subjects are also available at the British Library. More importantly, most newspapers during colonial Malaya can be retrieved in the British Library's newspaper collection at Colindale as well as its counterparts in various libraries in Singapore. Having fully published actual proceedings and minutes of meetings and discussions in addition to annual reports, these newspapers are the only traces left of many defunct organisations. .

[61] Marlene Manoff. "Theories of the Archive from Across the Disciplines", *Libraries and the Academies* 4:1 (2004): 9-25. p. 15.

[62] It is unfortunate that I have not been able to secure access to the main Malaysia archival Centre, the Arkib Negara. Unlike its counterparts, the Arkrib Negara is not a public archive and permits are not liberally given to non-Malaysians, especially researchers of Singaporean nationality. Nonetheless, I believe strongly that this would not compromise the project as substantial copies are available in the archives in Singapore and Britain.

Substantial documents of the RF activities in Southeast Asia during the Inter-War period are also available in the Rockefeller Archives Centre in New York City. They covered official reports on public health campaigns, correspondences and diaries of officers. Similarly, the League of Nations Archives in Geneva, Switzerland contains relevant secretariat files on the health reports on British Malaya, mainly on the subjects of rural hygiene, opium trafficking, the epidemiological station in Singapore and venereal diseases.[63] While the libraries of the National University of Singapore (NUS) and the National Archives of Singapore (NAS) boost similar collections with its counterparts in Britain on records on colonial Malaysia, the two institutions retain substantial amount of pre-war materials, particularly that of the medical journals and special reports.[64]

Collectively, the selection of materials here reflects what Jacques Derrida mentioned as the politics of "participation in, and access to the archives, its constitution and its interpretation."[65] The primary materials to be used in the reconstruction of the legacies of health lobbies in Malaya expose not just the characteristics of colonial civil society, but archival discourses in general. This emphasis in a way constitutes what John Comaroff describes as the clash of three models of colonialism. They are triangulated along namely, the state model which emphasized trade and alliances with native chiefs, the settler colonialism which converted chiefdoms to servile labour, and the civilising colonialism of missionaries. These otherwise competing strands came together in the production of evidence that was so central to colonial hegemony.[66] From my own observation, the relative prevalence of English language sources from Western organisations underscores the European predominance in the discourse of modern public health as authorial and autonomous subjects. Through reports, correspondence and publications left behind by these interest groups, subsequent chapters will assess their participation in the mapping and imagination of colonial territories and its inhabitants through the lens of biomedicine. Before the discussions of individual health

[63] Liew Kai Khiun. "The League of Nations Archives, Geneva. *Wellcome History*- Issue 31, (Spring 2006) p. 19.
[64] For details of medical archives in Singapore, see: Liew. "Archival materials in Singapore," *Wellcome History*-Issue 28 (Spring 2005) p. 17.
[65] Jacques Derrida. *Archive Fever: A Freudian Impression, trans. Eric Prenowitz* (Chicago and London: University of Chicago Press, 1995) p. 4.
[66] John Comaroff. "Images of Empire, Contests and Conscience: Models of Colonial Domination in South Africa," in Anne Stoler and Frederick Cooper. *Tensions of Empire* (Berkeley University Press, 1997). 179-81.

lobbies are expanded, it is crucial to stress that the representation of these groups are more selective than comprehensive.

This project may have spotlighted previously obscure players in the colony like the Rockefeller Foundation and Social Hygiene movement, and reassessed the legacies of familiar community merchant leaders, planting associations and anti-opium societies. It has also attempted to offer a glimpse of a broader social involvement in public health from the health emergency of the Spanish Influenza of 1918. Nonetheless, it remains problematic as the relevant archival materials continued to privilege the already prominent Western players. This becomes a problem if seen in the perspective of Dipesh Chakrabarty who feels that the move to "provincialise Europe" would be stalled if the Europeans continue to be placed in the spotlight, and if the colonised continue to be portrayed as reacting rather than acting.[67] However, I sense a potentially dangerous ideological implication of trying to wish away the European component in Chakrabarty's calls. In trying to defend the primacy of the European legacy in a rapidly decolonising Southeast Asia in the late 1950s, John Bastin nevertheless made a legitimate warning:

> It would be extremely dangerous if, in an anxiety to meet the political demands of a resurgent Asian consciousness, historians of Southeast Asia began to minimise too much the part played by Westerners in the region...Surely the plea for reinterpreting Southeast Asian history from an Asian point of view means something more than the convenient removal of Westerners from the historical narrative?[68]

Given the dilemmas, Edwin Lee found this spotlighting of the Europeans poses a continual problem in the historiography of Singapore as to "how much weight should be given to the indigenous component as opposed to the European, in the study of the history of Southeast Asia[...]?[69]

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[67] Dipesh Chakrabarty. "Postcoloniality and the Artifice of History: Who Speaks for the 'Indian Past'". Representation. 37 (Winter. 1992): 1-26. pp. 19-20.
[68] John Bastin. *The Study of Modern Southeast Asian History* (The University of Malaya in Kuala Lumpur. 1959) pp. 8-9.
[69] Lee. "The Historiography of Singapore". Kapur (ed). *Singapore Studies*. p.7.

Discussions on the advantages of the "native historians" rest on the presumption of their familiarity with their supposed geographically and culturally unchanging historical ovaries. However, this assumption deserves to be further problematised here. The emphasis of colonial modernity first by the British administration and subsequently by national governments under the ideology of development and industrialisation has continued to reinforce the primacy of western medicine. This results inevitably in the marginalisation of indigenous medical traditions, further de-legitimising their institutional and social memories as the documentation of these narratives and cultures become downplayed or discouraged.[70] The arbitrary predominance accorded to the English language and racialised notions of "mother-tongues" by the states in Singapore and Malaysia, has also handicapped local historians, like myself, raised in the postcolonial "national" environment, from the less reified appreciation of Malaya's more multicultural and pluralised past.[71]

Warning against abstracting the lived experiences of suffering and death by Western academia in Southeast Asia, Norman Owen points out:

> As scholars we must try to analyse such events; as human beings we must also be prepared to respond to them with empathy. But can we, with our Westernised, sanitised, 20th century minds, ever really understand how the people of Oas felt about death in three months of one third of all the little children in the parish?[72]

Coming from a "First World Oasis in the Third World", I do not pretend to represent the afflicted downtrodden. I do however empathise with Owen's dilemmas of the tendency

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[70] For example, the National Archives of Singapore (NAS) has undertaken a large oral history project, titled, "Development of Medical Services in Singapore" in documenting the voices of the republic's healthcare workers. Those involved were predominantly from state public health and medical institutions. Far less attention has however been catered to practitioners of folk medicine who have been classified in the NAS under part of its "Vanishing Trades" project. See also: Daniel Chew(ed). *Reflections and Interpretations* (National Archives of Singapore: 2005) and Lim Pui Huen, P. Morrision and Kwa Chong Guan (eds). *Oral History in Southeast Asia: Theory and Method* (Singapore: National Archives of Singapore and Institute of Southeast Asian Studies, 1998).

[71] For issues concerning the evolution of the English language in Singapore and Malaysia, see: John Platt and Heidi Weber. *English in Singapore and Malaysia* (Kuala Lumpur. Oxford: Oxford University Press, 1980) pp. 17-32, and Hugo Beardsomore. "Language Shift and Cultural Implications of Singapore", S. Gopinathan at el. *Language, Society and Education in Singapore: Issues and Trends* (Singapore: Times Academic Press, 1994) pp. 47-64.

[72] Owen. "Towards a History of Health in Southeast Asia", Owen (ed). *Death and Disease in Southeast Asia.* p.22.

of our works to conceal the "suffering in statistics."[73] Nonetheless, what this topic can do is to undertake the critical interrogation into the process in which the privileged defined and legitimised suffering.

The featured health lobbies had colonised the spaces of colonial civil society might have principally commanded the attention of governments. But, I strongly feel that it is these forgotten medical halls, local healers, folk remedies, death-houses and vernacular hospitals in the medical charities, whose routines have been either undocumented or lost, if recorded, that permeated into the rest of British Malaya. However tempting, it would also be dangerous to romanticise the hunt for "lost voices". According to Laurie Sears:

> It is not enough to find suppressed voices and marginalised speakers and reconstitute them as the subjects of their own histories. This, certain postcolonial scholars argue, may leave us blind to the ways in which knowledge was produced and disseminated in the colonial period as well as to the ways in which scientific, medical, and literary discourses, among others, were brought into being.[74]

Hence, albeit recognising the problematic selection of the available sources, this dissertation will still attempt to navigate a third way between the dominant narratives of Westerners in Asia and the search for a more exclusivist "Asian consciousness." Rather than just the celebratory reproduction of the texts, the core priority of a more critical and balanced study is to position these materials within the question of how "knowledge" and more importantly, power, were being "reproduced and disseminated" within the particular context of British Malaya.

Chapter Outlines

The exploration of health movements will be compressed into six chapters. Such an arrangement arranged principally according to the socio-geographical categorisation of health and diseases in the colony. Chapter One presents an overview of the medical infrastructure of the colonial services vis-à-vis the activities of the health movements in British Malaya. First coined by the colonial official Frank Swettenham, this entity is commonly referred to by historians as the Malayan Peninsula stretching from Singapore

[73] Ibid.
[74] Laurie Sears. "The Contingency of Autonomous History". Sears. *Autonomous History*. p.3.

in the South to the current borders of Thailand.[75] The political and administrative arrangements of British Malaya were radically different from that of the contemporary nation-states of the Malaysian Federation (including Sabah and Sarawak), the Sultanate of Brunei, and the Republic of Singapore. Instead, they were divided along the Straits Settlements (Penang, Malacca and Singapore), the Federated Malay States (Negri Sembilan, Perak, Pahang and Selangor), and the UnFederated Malay States (Johore, Kedah, Trengganu,Kelantan and Perlis). Although one will suspect a more Singapore-centric bias here, the mapping of health lobbies in British Malaya exposes the limitations of "national" historiographies in Singapore and Malaysia seeking to confine the past to their current territorial borders.[76] Given the socio-economic networks across these demarcations, attempts to produce an integrated history of Malaysia generally, or even a separate history of Singapore tend to be misdirected.[77]

This chapter provides a layout of the development of the colonial medical services and its expansion of public health functions. Even with the increasing emphasis on non-state agents the trends of social history, the awareness of the role of the state must not be sidelined. As Prasannan Parthasarathi stresses: "By ignoring the state, a false dichotomy is created between the private and the public, with the result that private life is often portrayed as autonomous of the state. Yet state actions and institutions have played a central role in shaping private life[...]Therefore, to ignore the state is to seriously distort our understanding of both past and present."[78] Correspondingly, Chapter One also surveys the fabric of colonial civil society in Malaya in which the health lobbies were predominantly situated. In turn, this section will map out the platforms and areas in which the agencies of state and society interacted in British Malaya. Urban health takes centrestage in Chapter Two. As trade expanded in the urban colonial settlements of mainly Singapore and Penang, the migrant population grew, imposing greater public health stress for the authorities. This chapter focuses on the extent of influence exerted

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[75] Frank Swettenham. *British Malaya; An Account of the Origin and Progress of British Influence in Malaya* (London: John Lane, 1906).

[76] For a discussion of the writing of national historiography in Singapore, see: Albert Lau. "The National Past and the Writing of the History of Singapore," Ban Kah Choon, Anne Pakir and Tong Chee Kiong (eds) *Imagining Singapore* (Singapore: Times Academic Press, 1992) pp. 46-68.

[77] Paul Kratoska. "Country History and the Writing of Southeast Asian History", Ahmad and Tan (eds). *New Terrain in Southeast Asian History*. p.114

[78] Prasannan Parthasarathi. "The State and Social History", *Journal of Social History*, 39:3 (Spring 2006):771-8. p. 773.

by community leaders and organisations in the areas of urban sanitation, hygiene rules, and the licensing of food and drugs.

From there, the project moves onto the areas of Rural and Estate health in the Third and Fourth chapters dealing with health lobbies faced with the expansion of plantation agriculture and rural populations. Two main subjects, namely the involvement of the Plantation associations and the International Health Board (IHB) of the Rockefeller Foundation will be awarded significant attention. For the former, the constant conflict with the government over the control of malaria and estate worker's health became entangled with the macro issues of private responsibilities against public obligations in the running of health institutions and other related services. In contrast, the RF sought to work with the government in starting rural health centres with the aim of propagating public health education through the anti-hookworm campaigns to be discussed in Chapter Four. Chapter Five places the episode of the 1918 influenza under scrutiny as a case of state-society relations in the context of a health emergency. It gauges the rate in which the government and society were able not only to mobilise resources to contain the epidemic, but also providing leadership and direction in the midst of the disturbance.

In the previous chapters, vector and respiratory-based infectious diseases, or what Brian Inglis describes as the "old indiscriminate diseases", dominate the discussion. In Chapters Six and Seven, this is replaced by the examination of health movements related to the social evils of opium addiction, maternal mortality and venereal diseases, or in Inglis's terminology, the "discriminating disorders of civilisation".[79] With its beginnings in the early 20th century, the predominantly ethnic Chinese anti-opium societies in British Malaya lobbied for the criminalisation of the narcotic as well as providing rehabilitation of addicts. European women in British Malaya lobbied to improve the health and dignity of their Asian counterparts through medical missions and social hygiene groups like the British Social Hygiene Council (BSHC) and the Association for Moral and Social Hygiene AMSH). These women believed that what they saw as the primitive midwifery practices and official acquiesce in vice had resulted in the poor state of reproductive and sexual health of womenfolk in the colony. Nevertheless, the efforts of the temperance movements created considerable tensions among colonial society in Malaya. It is in these two chapters where the differences

[79] Brian Inglis. *Fringe Medicine* (London: Faber & Faber, 1964) p.18

between the abolitionists and regulationists over outlawing opium consumption and prostitution as indicative of broader ideological agendas of health lobbies, will be prominently featured.

It must be emphasised here the arrangements of chapters serves to reflect the more fluid spaces in which the health lobbies operated. To begin with, the simultaneous urbanisation, expansion of commercial agriculture and population growth in British Malaya renders the neat delineation between urban, estate and rural boundaries difficult. In addition, these social boundaries seemed irrelevant to infectious diseases like malaria, ankylostomiasis, influenza and syphilis as well as opium addiction which afflicted the urban dweller as much as the estate coolie and villager. As such, the quarantine centres, medical college, malaria courses, public health education and social hygiene programmes instituted by health movements would be seen to be of benefit to the clientele within the intersecting urban-rural-estate spaces in the fringes of the municipalities surrounded by market gardens, rubber estates and villages. As Chapters Three and Seven will show, the estate hospitals were utilised by patients by neighbouring kampongs, and the medical mission established facilities in both the rural heartlands of Malacca and the urban slums of Singapore. In the same light, the temperance messages of the anti-opium societies in Chapter Six were meant to address Chinese compatriots in the busy ports as well as isolated tin mines and plantations. Recognising this fluidity, the chapter layout attempts to accommodate the spatial aspects of health politics as far as possible with Chapters Two to Five set within actual physical contexts against the idealised spaces that the temperance movements were lobbying for in Chapters Six and Seven.

Spelling out the Range of Possibilities

Claiming the importance of a microhistorical approach, Giovanni Levi urges for further scrutiny of players in civil society in order to expose the undercurrent dynamics of "big systems."[80] The health lobbies offer a possible scenario in which the discourses on the socialisation and hierachisation of diseases can be more vividly elucidated through their efforts to mobilise and politicise health by appropriating medical discourses to view broader social issues. More importantly, these activities serve as gauges to a more

[80] Gylfi Magnusson. "The Singularisation of History: Social History and Micro-History within the Postmodern state of knowledge", *Journal of Social History*, 36:3 (2003):701-35. p. 714.

hierarchised emphasis placed on infectious diseases. At the same time, this hierarchy may help link the otherwise separate studies of individual malaises in specific regions. Placed in the historical context of the colonial era, these health movements engendered interactions and networks that deserve greater attention by medical historians. Finally, the transnational profiles of these groups provide opportunities to transcend the state-centric historiographies.

As Cooper stresses, "the point of historical analysis is not to commend one kind of politics or condemn another but to spell out the range of possibilities, the consequences that could ensue from each, and the possibilities of different trajectories following upon particular combinations of actions."[81] With these considerations in mind, the subsequent chapters will elaborate on the involvement of health movements in Colonial Malaya. The resultant medico-political cartography displayed by these health movements will in turn highlight the layers of interactions, and their possibilities and limitations in reordering society.

[81] Frederick Cooper. *Colonialism in Question: Theory, knowledge, History* (University of California Press, 2005) p. 232.

Chapter 1:
Piper & Tune: Colonial Public Health, State and Civil Society

But, if we ask what is or has been the historical origins of the state in general, still more if we ask about the origin of any particular state, of its rights and institution, or again if we inquire whether the state originally arose out of patriarchal conditions or out of fear or trust, or out of corporations etc, or finally if we ask in what light the basis of the state's rights has been conceived or consciously established...all these questions are no concern to the Idea of the state.[1]

Hegel.

British administration has brought the Federated Malay States out of chaos to order and prosperity. Land hitherto living idle and waste has been cultivating. Districts uninhabited but a few years ago are now dotted with active and prosperous mining towns. Drainage and irrigation works have been introduced. Roads, railways and telephones have been constructed throughout the states. The various ports have been furnished with wharves and every facility for taking in, discharging and transporting cargo. Schools have been opened in every town and kampong. A just and settled government has everywhere rendered life and property secure. Allowed to lead their lives in their own fashion, the Malays are contented, happy and peaceable.[2]

C.M. Philips. *A Textbook of the Malay Peninsula*

Introduction: "Historical origins of the state"

British East India Company control in Asia ended with the 1857 Indian Mutiny and the consequent transfer of authority from shareholders to state. Among one of the outstanding contentions of the new arrangements was the financial responsibilities of a military garrison in the colonial outposts in Malaya.[3] Officials and merchants in India and Singapore felt strongly against shouldering the cost. However, they feared the loss of their autonomy if London became more involved. Frank Swettenham, the venerable British colonial administrator in Malaya, summarised these considerations where "Who pays the piper shall call the tune, it would follow that, who calls the tune shall pay the piper."[4] Until the Japanese invasion in 1941, British Malaya was embroiled in this negotiation for equilibrium between officialdom and community.

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[1] G.F.W. Hegel. "Philosophy of Right", in Virginia Hodgkinson and Michael Foley (eds) *The Civil Society Reader* (Hanover and London: Tufts University, 2003) p.94.

[2] C.M. Philips. *A Textbook of the Malay Peninsula* (Education Department, Straits Settlements, 1904) p.55. (National Library Board, Singapore).

[3] Nadzan Haron. "Colonial Defence and British Approach to the Problems in Malaya, 1874-1918", *Modern Asian Studies* Vol.24, No.2 (May 1990), 275-95.

[4] Sir Frank Swettenham. *British Malaya*. p.107.

This chapter places the development of the medical health services within the context of state-civil society interactions in British Malaya. The discussion will commence with an examination of the conceptual understanding of the state and its more specific historical manifestation in the context of public health. Against the backdrop of the development of British political hegemony in colonial Malaya, it traces both the extension and extent of the colonial medical services and underlying agendas and tensions in its prioritisation of infectious diseases. From the confines of prison hospitals and ship surgeons in the mid 19th century, the public health regime grew to cater for a larger clientele with medical facilities like district hospitals and outdoor dispensaries in otherwise more inaccessible areas. Accompanying these provisions were compulsory medical screenings and treatment of the general populace as part of the strengthening of the legal authority of public health regimes. This was followed by greater emphasis towards preventive sanitary and drainage works as public health education. This chapter will also explore how the colonial state classified and calibrated its responses to infectious diseases based on mortality rates, endemicity and prevalence.

Rather than a nebulous timeless entity, this study serves to highlight the colonial public health regime as a developing historical agent shaped by its external socio-economic environment. This interaction will be explored at three levels, namely, the difficulties encountered within the medical bureaucracy, the responses of their clients, particularly indigenous society, and colonial civil society's participation. It is also in this chapter where platforms for health lobbies within colonial civil society will be further discussed. Rather than being external to the apparatus of the state, community organisations, health movements, merchant associations and philanthropists will be shown to being closely intertwined with its development. Instead of being passive recipients of state policies, the chapter outlines the process in which health lobbies facilitated the participation, policing and enlargement of colonial civil society.

'Philanthropic Ogre' or 'Institutional Ensemble'

A critical appreciation of health movements in British Malaya requires a preliminary interrogation of the primacy placed on the colonial state. The fundamental question here is the extent to which public health in the colonial context can be neatly defined, represented and projected by a seemingly ahistorical state.

Ali Kazancigil defines the modern state as one that:

> [...]has at its disposal a bureaucratic apparatus, established along the legal-rational pattern, with a precise division of task and functions, and a personnel which identifies with it, reproduces a specific ideology and carries out the tasks of administration, taxation, justice, police and defence[...]It intervenes very actively in the economic, cultural and ideological spheres of society, as well as in the private lives of its citizens.[5]

The representation of the state as both primary administrative units and pivotal political entities is in turn mirrored in the innumerable works devoted to understanding of political leaders and public administrations. Closely associated with the security apparatus, the state is seen to claim the monopoly of violence; a monopoly legitimised by a combination of consent and coercion. Ironically, it is also the same apparatus, which concerns itself with gaining the dominance, if not monopoly, over public health, occasionally, through the acts of compulsion. While the state can be readily associated with the custodian of law and order, its provision of general public services calls for a broader discussion. Although secondary to its core responsibilities, these public functions are thought to be integral in establishing the hold of government.[6]

The military and economic locomotion of state power for example, demands the availability of fit soldiers and productive workers drawn from a generally healthy population. In this respect, public health authorities are empowered to embark upon a series of measures ranging from compulsory vaccination and slum clearance, enforcement of legislation on health standards to aggressive public education on

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[5] Ali Kazancigil. 'Paradigms of Modern State Formation in the Periphery', in Ali Kazancigil (ed). *The State in Global Perspective* (Paris: Unesco, 1996) p.119.

[6] This idea was not only deemed applicable in the European historical context on the development of absolutism, but also in the postcolonial countries whereby the "modern" institutions like the military, were regarded as the driving force of modernisation. See: Samuel Huntington. *The Soldier and the State: The Theory and Politics of Civil-Military Relations* (Cambridge : Belknap Press of Harvard University Press, 1957), Theda Skocpol. *States and Social Revolutions: A Comparative Analysis of France, Russia, and China* (Cambridge University Press, 1979).

individual hygiene. While, these measures are not unprecedented, they have been prevalently associated with the establishment of the European modern state. Such measures also coincided with the rhetoric of the rising faith in the innovations in biomedical science by the 19th century as a tool of progress and modernity.[7]

These modern European states also accelerated the colonisation of non-European territories. What started as rudimentary attempts of separating colonial armies and settlers from "diseased" indigenous population were subsequently systematised into public health regimes of hospitals, medical research institutions and sanitary departments.[8] Taken together, such interventions by the colonial state legitimated imperial rule where "clean water supplies, water borne sewage systems, hospitals, clinics, medical training and so on were advanced and lauded as some of the great civilising benefits of European rule by contemporaries and historians."[9] Working together with other agencies from education to survey departments, the colonial state sought to reshape the social fabric of their subjects.[10] In effect, it was portrayed as an agent for disciplining the colonised body to conform to the ethos of the colonial economy and society.[11] Although less explicit than military might, the tentacles of the colonial medicine were significantly disruptive, displacing folk healing cultures, increasing dependency on Western medical facilities, and heightening socio-medical surveillance.[12]

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[7] Dorthy Porter. *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999). Mark Harrison observes the ascendancy of germ theories following the first bacteriological discoveries reoriented public health away from environment causes to that of individual activity. Increasingly seen as carriers of not just diseases, but also potential vehicles of transmission, new methods were designed to prevent man from spreading diseases, in which the instruments of the state was most equipped to carry out. *Disease and the Modern World: 1500 to the Present Day* (UK, USA: Polity, 2004) p.119.

[8] Harrison. *Public Health in British India: Anglo-Indian Preventive Medicine* (New Delhi: Foundation, 1994) pp. 60-98.

[9] Margaret Jones. *Health Policy in Britain's Model Colony* (New Delhi: Orient Longman, 2004) pp.5-6.

[10] Kavita Philips. *Civilising Natures; Race, Resources and Modernity in Colonial South India* (New Delhi: Orient Longman: 2003).

[11] See: Arnold. *Colonising the Body.*

[12] See: Martin Shapiro. *Medicine in the Service of Colonialism: Medical Care in Portuguese Africa, 1885-1974* (PhD thesis: University of California, Los Angeles, 1983), Mridula Ramanna. *Western Medicine and Public Health in Colonial Bombay, 1845-1895* (London: Sangam Books, 2002), Myron Echenberg. *Black death, White Medicine: Bubonic Plague and the Politics of Public Health in Colonial Senegal, 1914-1945* (Portsmouth, NH : Heinemann : Oxford : James Currey, 2002), Maryinez Lyons. *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge ;New York:Cambridge University Press, 1992), Jock McCulloch. *Colonial Psychiatry and "the African Mind"* (Cambridge: Cambridge University Press, 1995), Warwick Anderson. *Colonial Pathologies : American Medicine in the Philippines, 1898-1921* (PhD Thesis: University of Pennsylvania, 1992).

Hence, given the metaphor of the *philanthropic ogre* by Mexican poet Octavio Paz, the modern state continues to fascinate as a hegemonic power to dominate and/or protect. The formation and projection of power by the state is categorised generally by Maurice Godelier between that of exogenous and endogenous. The former describes a situation of direct subjugation of society by an outside force while the latter is an outcome of an ascendant segment of society gradually establishing its predominance and control of the governing apparatus.[13] Together, the works written on the experience of the operation of the colonial state largely concurs with the exogenous-endogenous model whereby European colonialism was either swiftly imposed or eventually extended.[14]

Although the concept of the modern state has become a more universal phenomenon, its transformation has also shaped by specific local conditions. While the functions of the state have reached a degree of universality, the shaping of not just the institutions, but, the discourses of governing bodies have been more complex or messier. Describing the absence of the concrete behind the façade, Christopher Pierson contextualised the composition of the state:

> The terrain of the state is contested by a diversity of social forces pursing a diversity of social projects. It is not a unitary force, but rather 'a specific institutional ensemble with multiple boundaries, no institutional fixity and no pre-given formal or substantive unity[...]Any substantive unity which a state system might possess derives from specific political projects and struggles to impose unity or coherence on that system' The actual outcomes of struggles on the terrain of the state reflect the existing balance of social forces structured, in part, by the sedimentation of the outcomes of earlier struggles.[15]

Urging a move from the thinking of the state as a 'master fiction', political theorist Victor Perez-Diaz takes into account the fact that the state has to confront civil society in a plural capacity as a prominent rather than dominant actor in the public sphere.[16] The difference between various state systems lies in the extent of civil society participation. Such can be gauged in public platforms from the media to government

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[13] Maurice Godelier. "Process of state formation", in Kazancigil(ed). *The State in Global Perspective*. p.3.
[14] More recent observers of colonial governance have favoured the nuances of indirect rule, or patron client relationship over that of the imposition of centralised bureaucracies Colin Newbury. "Patron Clients and Empire: The Subordination of Indigenous Hierarchies in Asia and Africa", *Journal of World History*, 11.2 (2000). 227-63, John Murphy. "Legitimation and Paternalism: The Colonial State in Kenya", in *African Studies Review*, 29:3 (Sep. 1986):55-65. p. 62.
[15] Christopher Pierson. *The Modern State* (London, New York: Routledge, 1996) p. 63.
[16] Victor M. Perez-Diaz. *The Return of Civil Society: The Emergence of Democratic Spain* (Cambridge, Massachusetts: Harvard University Press, 1993) pp. 66-9.

committees and legislative bodies where civil society seeks to be represent, or is allowed to be represented. This leads to the next discussion of the concept of civil society and its relation to public health.[17]

Edward Shils defines civil society as "part of society which has a life of its own, which is distinctly different from the state, and which is largely in autonomy from it. Civil society lies beyond the boundaries of the family and the clan and beyond the locality; it lies short of the state."[18] Interest groups and associations in civil society are the mediating components between the individual and the state. Through them, as Gabriel Almond and Sidney Verba have elaborated, "the individual is able to relate himself effectively and meaningfully in the political system...He [becomes] involved in the broader social world but is less dependent upon and less controlled by his political system."[19] In fact, Peter Evans describes as the "zero-sum relation between the robustness of the state institutions and the vibrancy of civil society" as hampering a more complex understanding of the interactions of these two forces[20] In contrast, he proposes the possibilities of a more inter-dependent relationship between state and society where the evolution of a vibrant civil society could actually be manifested in the development of a more advanced state.[21]

Beyond their philanthropic functions, the involvement of civil society in the formation of social medicine remains insufficiently theorised. As the latter was predominantly confined to court medicine until the advent of the mass society in the Industrial Revolution, the role of the government was relatively limited. Aside from private and commercial medical services, the sick were served by a combination of guilds, charities and religious bodies.[22] It is crucial at this point to particularise these discussions within

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[17] Formulated by Talcott Parsons, the idea of a "sick role" recognises that illness is not merely a state of the organism and/or personality, but comes to be an institutionalised role, which is to say, the sick role is not a condition of an isolated body but is achieved interpersonally within a particular social/cultural milieu. Arthur Frank. "From sick role to health role: Deconstructing Parsons", in Roland Robertson and Bryan Turner (eds). Talcott Parsons. *Theorist of Modernity* (London: Sage, 1991) pp. 205-6.

[18] Edward Shils. "The Virtue of Civil Society", in Virginia Hodgkinson and Michael Foley, *The Civil Society Reader*. p. 292.

[19] Gabriel Almond and Sidney Verba. "The Civic Culture". Ibid. p. 173.

[20] Peter Evans. "The Eclipse of the State? Reflections on Stateness in the Era of Globalisation", *World Politics*, 50.1 (1997) 92-87. p. 79.

[21] Ibid. pp. 84-6.

[22] Thomas Adam (ed). *Philanthropy, Patronage, and Civil Society : Experiences from Germany, Great Britain, and North America* (Bloomington : Indiana University Press, 2004), Bernard Harris. *The Origins of the British Welfare State: Society, State and Social Welfare in England and Wales, 1800-1945*

the historiography of British Malaya to appreciate the undercurrent social dynamics of health lobbies in the colony.

Background of political developments in Colonial Malaya

The formation of the modern state in Malaya runs parallel to the expansion of British colonial control; a view held by British administrators and historians subsequently. Such have been commonly explained by the successful political manoeuvring of British administrators against indigenous rulers. Accompanying the acceptance of "enlightened" advice of the British was the development of the local economy and introduction of modern system of governance.

British hegemony in Malaya was however established out of general reluctance and its extension largely piecemeal.[23] With its initial intention for merely trading outposts in the Straits of Malacca to tap the China trade, the British East India Company tried to avoid the financial burdens of administration.[24] In fact, the establishment of the Straits Settlements of Penang, Malacca and Singapore by 1824, and efforts to contain Siamese influence in the Malaya were frowned by higher authorities preferring "non-interference."[25] The hands-off approach continued even after the Straits Settlements was transferred from the India to the Colonial Office in 1867. In the early 1870s, the British remained nervous spectators of a raging civil war among the various principalities in the Malayan Peninsula, threatening both commerce and security. Under intense pressure from merchants and pro-British warring factions, an agreement was brokered in the Treaty of Pangkor in 1874; a milestone for the introduction of the system of indirect rule under the Residential System.[26] Although establishing control by federating the

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(Basingstoke : Palgrave Macmillan, 2003) and Alan Kidd. *State, Society and the Poor in 19th Century England* (Basingstoke : Macmillan, 1999).

[23] For a more general history of British colonialism in the region, see: Mary Turnbull. *A History of Malaysia, Singapore and Brunei* (London: Allen & Unwin, 1989).

[24] See: C.M Turnbull. *The Straits Settlements, 1826-67: Indian Presidency to Crown Colony* (London: Athlone Pres. 1972).

[25] N.J. Ryan. *The Making of Modern Malaya: A History from Earliest Times to the Present* (Kuala Lumpur: Oxford University Press, 1963) pp. 92-8

[26] As explained by the Chief Secretary of the Federated Malay States William Maxwell to the Colonial Office on the background of the Residential System: "In each state, the British Resident, though nominally only an adviser to his sultan, was really the sole administrator. He was subjected to the instructions of the Governor of the Straits Settlements, and applied to him for directions in matters of importance. But inevitably, each Resident worked on his own lines." PRO/CO882/10. "Policy of Decentralisation and Constitutional Reorganisation in the Federated Malay States. Eastern No. 142, May 1925. W.G. Maxwell to Colonial Office- Notes on policy with regards to the UnFederated Malay States. 18 October 1920.

four main Malay states of Perak, Selangor, Pahang and Negri Sembilian in 1895, the pendulum of British policies swung between centralisation and decentralisation of administrative functions. In a note approving the scheme for federation between the four Malay States in 1895, the Secretary of State for the Colonies desired:

"[...]no pains should be spared to safeguard the position and dignity of the Native Rulers, to invite them to cooperate as fully as heretofore with their British Advisers in promoting the advancement of their respective territories and subjects, and to give them the assurance that such changes as shall be made are solely intended to promote strength by combination, uniformity of policy and harmony of purpose."[27]

The difficulties of resolving these apparently conflicting goals were revealed as grievances as the Federal system was implemented. In the opinion of Governor John Anderson, "The Federated Malay States had been tied up into far too tight a knot, and the difficulty was to know how to undo it.[28]

By the eve of the First World War, British territorial control to the present boundaries of Malaysia was complete. The last independent state of Johore was compelled to enter the Residential system in 1914, and the incorporation of the Four Northern Malay States of Kelantan, Kedah, Trengganu and Perlis from Siamese control in 1909.[29] Nonetheless, the extension of the administrative machinery to these states was more gradual. Rather than pushing them into integrating with the Federal government, these states were allowed to function "as usual" as Unfederated Malay States.[30] Within the directly administered Straits Settlements, the British officials struggled to maintain law and order with a tiny police force and token military presence.[31] If the strength of the state is determined by the ability to monopolise the use of violence, the colonial government's grasp was limited as evident in absence of absolute authority in the military security of the colonial during the late 1930s.[32]

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[27] Ibid. p.A3.
[28] Ibid. p.A4.
[29] See: Nesamalar Nadarajah. *Johore and the Origins of British Control, 1895-1914* (Kuala Lumpur : Arenabuku Sdn. Bhd., 2000) and Thomas Mark. *The British Acquisition of Siamese Malaya, 1896-1909* (Bangkok: White Lotus, 1997).
[30] Yeo Kim Wah. *The Politics of Decentralization: Colonial Controversy in Malaya, 1920-1929* (Kuala Lumpur ; Oxford University Press, 1982).
[31] George Maxwell. *Problems of Administration in British Malaya* (New York:International Secretariat, Institute of Pacific Relations, 1944).
[32] As Brian Farrell echoed the frustrations of military commanders: "The whole country was in fact administered by a British civil service that answered to the Colonial Office, but preserving Malay sensitivities meant working through layers of administration. Any measures requiring government

Even as the territories were under the British Empire, the actual political arrangements were historically more awkward as seen from the evolution of different administrative entities within Malaya. As T.N. Harper poignantly noted, this defied the conventional yardsticks of recognising political authority in Malaya whereby: "Any study of the colonial state in British Malaya is complicated by the fact that, strictly speaking, the British presence was not a state at all, rather it worked on the pretence that it was a state. Theoretically, it was not sovereign."[33] In his opinion, the more concrete impact of the colonial Malayan state came from for four areas. Identified as the main pillars of British governance, these entailed the professionalisation of administration, the implementation of the rule of property (after 1891), the creation of new centres of power in Singapore and Kuala Lumpur, and the enlargement of "technological competence" like education and public health.[34] It is in the fourth pillar the following sections will be devoted to covering the "enlargement" of the colonial medical services as part of providing a more tangible understanding of the colonial state.

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assistance or approval had to go through eleven different offices if it were countrywide-the Straits Settlements plus the mainland states of the Federal Government...[General] Perceval put it well: It should be realised that[...]Malaya did not have a free hand in developing the defences of Malaya." Brian Farrell. *The Defence and the Fall of Singapore* (United Kingdom: Tempus, 2005) p. 113.

[33] T.N. Harper. *The End of the Empire and the Making of Malaya* (United Kingdom: Cambridge University Press, 1999) p. 18.

[34] Ibid.

Capillaries of the State: The Arms and Legs of Colonial Medicine

The priorities and influences of the colonial medical services over the Malayan territories can be appreciated through its administrative and infrastructure developments.[35] In general, the chronology of the colonial government's provision in health services is one of expansion, consolidation and centralisation. Until the 1870s, the provision of public services including that of medical services, was considered rudimentary. [36] According to Phua:

> The story of health services in the British colonies had begun with the arrival of the 'ship surgeons' on board the sea-faring vessels of the English East India Company. As colonial trading post were established, military or garrison doctors who accompanied the security forces usually extended their services to the rest of the colonial administration and the colonists as well.[37]

The main components of the early annual medical reports were confined to that of health of prisoners in goals and admission rates in "anti-mendacity hospitals" run by private charities. [38] From the scattered epidemiological records and vaccination programmes, it can be inferred that medical provisions were undertaken by the individual initiatives of the medical officers instead of systematic public health measures. Phua observes the first steps towards the crystallisation of the colonial medical services coincided with the transfer of the political supervision of the Straits Settlements in 1867 from India to be directly under London as a Crown Colony, a move that had supposedly given greater autonomy to the local colonial authorities. During this period, several legislations on quarantine and contagious diseases were passed, authorising the mandatory medical examinations, quarantine and treatments of infected persons. At the same time, rural and urban sanitation were increasingly recognised as separate fields of work where such functions were appropriated by the municipal department.[39] A landmark development of the medical infrastructure during this period

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[35] Even as her focus was on the role of the state medicine, Manderson only devoted three pages towards the infrastructure expansion of the colonial medical services. Instead of a more systematic examination of trends, Manderson's description of the development seems to be based on the random extraction of details from the various annual reports of the colony. See Manderson. *Sickness and the State.* pp. 63-5.

[36] For a more detailed narration of the public health in the colony before 1867, see: Lee. *Medical History of Early Singapore.*

[37] Phua. *The Development of Health Services in Malaya and Singapore.* p. 357.

[38] See *S.S.A.R*: 1850-1870.

[39] Phua Kai Hong. *The Development of Health Services in Malaya and Singapore.* pp. 11-35.

came perhaps in the establishment of the Saint John's Island quarantine centre in Singapore in 1873 for incoming passengers to the settlement.[40]

With three main centres in Singapore, Palau Jerejak in Penang and Port Swettenham, the quarantine centres became one of the main feature of the colonial medical services. As shown in Table 1, Appendix 1 of Annex A, with the huge numbers of passengers screened, it was also one of the main sites in which the presence of the state was felt.[41] From the increasingly detailed statistical reports and analysis, a significant feature of the colonial administration was the move towards a more routinised monitoring of the pulse of the territory's socio-economic activities. Underlying this process was the creation of a colonial census regime that served to lengthen the tentacles of the state. Other than returns on trade and revenue, figures on public health had also been given crucial attention where:

> [With more complete statistics] we are now able to determine with some precision the limits of mortality and its causes, and are being led up to the consideration of the causes which bring about a high death rate[...]By its means, we are able to submit to numerical analysis the facts relating to the laws of vitality, the influence of age and sex, of civilisation, occupation, locality, season and many other agencies; and our knowledge of all the facts bearing on health and disease has attained a precision never before known. [42]

From the confines of individual hospital admission rates in the 1850s, the data was expanded into broader mortality figures as well as detailed diseases categories in individual territories. By the 1930s, the statistical range covered the entire Malayan Peninsula as the colonial government attempted to develop a more uniform administrative structure.[43]

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[40]In formally declaring the establishment of a quarantine regime, the Governor of the Straits Settlements announced: "While initiating means for diminishing local disease, it is essential that preventive measures should be taken to guard against epidemics from abroad." *S.S.L.C.P.* 21 March 1874. p.2.

[41] Apart from the screening of incoming passengers, particularly migrants, the quarantine centres were also equipped with hospitals and treatment facilities for serious cases of infection as well as for general preventive health (see Table 2, Appendix 1 of Annex A).

[42] Dr W.R.C Middleton and Lim Boon Keng. " Investigation on the registration of causes of deaths occurring within the Town of Singapore." 21 October 1896. p. 1 (From *S.S.L.C.P*, 1896).

[43] Spread across more than a century over several different political and administrative entities, it is almost impossible to obtain standardised and consistent statistical records concerning the colonial medical services. With the changing of medical officials coupled with shifting priorities and the expansion of medical services, most statistical trends established in medical reports were often inconsistent. Unfortunately, similar information from the Federated and UnFederated Malay States are either absent or inconsistent. Hence, greater reliance has been placed on the records of the Straits Settlements that are demonstrated to be more consistent.

Concurrently, the colonial medical services were beginning to be replicated in the Malay States with the introduction of the Residential System. Medical officers from the Straits Settlements were seconded to assist the British Resident to establish health departments and medical facilities, and carry out demographical and epidemiological surveys.[44] Unlike the Straits Settlements, the colonial medical services in the Malayan Peninsula were faced with significantly more expansive territories scattered and increasingly transient populations. Aside from setting up more district hospitals, a novel scheme of outdoor and travelling dispensaries was devised by Dr Hamilton Wright to reach out to the rural population.[45] This concept marked the crucial beginnings in the expansion of colonial medicine to the indigenous population through the subsequent development of a network of travelling dispensaries and rural health centres.

By the early 20th century, the colonial medical services began to focus on maternal and infant health, motivated both by the rising rates of female immigration as well as imperial concerns for maternal welfare as an indication of the Empire's vitality.[46] As the annual medical reports featured infant and maternal mortality rates prominently, more facilities and wards in hospitals were established for female patients. Among the concerns of colonial medical officials were the general absence of modern obstetric and paediatric services. From the 1910s, the government implemented a series of midwifery legislations aimed at training not just folk midwives along modern European medical practices.[47] Measures were also taken to cultivate a core of local nursing staff along similar patterns with the longer term intention of replacing traditional practices. Meanwhile, government nurses and doctors, predominantly European women medical staff conducted regular visits to rural kampongs with the intention of educating women on the principles of basic personal hygiene and healthcare.[48]

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[44] The Resident of Perak described for example, the moves to establish a hospital in every district of the State at the expense of government funds and to bring in qualified medical doctors to run these institutions under the overall directions of the Residency Surgeon. *Annual Report for Perak*. 1885. p. 18.

[45] The first outdoor dispensary was opened in Singapore in 1881 and was reportedly well received with an attendance of 837 patients in 1884. A second outdoor dispensary was opened in Penang in 1883 following the success in Singapore. See: *S.S.A.R*, 1883. p. 212

[46] According to Manderson, the concern for maternal and infant health by the colonial authorities as a potential substitute for immigrant labour where locally born workforce was thought to be healthier and therefore cheaper than its foreign counterpart. See: Manderson: *Sickness and the State*. pp. 201-229.

[47] Ibid. pp. 206-211.

[48] The first concrete attempts to grapple with the issue of maternal health arouse in the 1910 where a European municipal nurse was appointed to secure information of the conditions of infants and mothers. A system of training and licensing of midwives was established a year later. By 1912, the nurses paid about 8855 visits and saw 3,444 infants while government trained and approved midwives delivered 140

Beginning with individual initiatives from medical officials,[49] public health education became a feature of the colonial medical services in Malaya by the 1920s. Accompanying medical and dental inspections in schools and villages were lectures and demonstrations on preventive health and public hygiene. Emphasizing the paramount importance of public health education for especially schools as part of preventive health work, the Chief Health Officer for Singapore, Dr Gilbert Brooke reported:

> The incidence of infectious disease in a great seaport such as Singapore is always of international interest. Smallpox and cholera, plague and enteric, dysentery and phthisis and malaria are a great septette of tropical infections which, like the poor, are always with us; but the infinite tragedy and pathos of the whole thing lies in the fact that they are all preventable diseases. I am convinced that the key to the situation lies in the school-room from which alone can spring that intelligent personal appreciation and whole hearted public cooperation which we shall never be able to efface the all-pervading and disgraceful blot on the page of our much vaunted modern civilisation.[50]

Basic anti-malaria measures like oiling and drainage, use of anti-mosquito nets and also latrine construction were shown to persuade the local populace to participate more actively in the public health process.[51] At the higher level, keen on training its own local medical officers instead of being reliant on Britain and India, the colonial government expanded medical education through Singapore based medical college, established in 1905. Medical research into tropical diseases was also encouraged through the Institute of Medical Research, located in the Federal capital of Kuala Lumpur.

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cases. Ibid. pp. 211-229. With the introduction of the Midwives Ordinance Board in 1923 making registration of midwives compulsory, there were a total of 320 licensed midwives in Singapore. 130 in Penang and 26 in Malacca. In addition, two maternal clinics were set up in the Prinsep and Kreta Ayer Streets of the Singapore Municipality during the same period. *S,S,M,R.* 1925. pp. 32-33. See also: I.M.M. Simmons. "Pioneering Maternity and Child Welfare Work in Rural Singapore, 1927-1934". *Public Health Nursing.* Vol.27. 1935.

[49] An example of such initiatives was Dr Keun's lectures and pamphlets on maternal health to villagers in Malacca in the Malay vernacular in 1915 undertaken to prevent what he thought were the unhygienic practices of the local womenfolk. Ibid.1915. p. 2.

[50] Ibid. 1927. p. 732.

[51] Routine public health education involves distribution of literature as well as lectures by members of the Public Health Education Committee, the Malaria Advisory Board and the Infant Welfare Advisory Board. Propagated in the vernacular languages, this covered topics on hookworm diseases, convulsions, dental hygiene, advice to nursing mothers, leprosy, venereal diseases, opium addiction as well as general personal hygiene. FMSAR. 1922, p. 25.

Such efforts at expanding public health education at various levels, from the raising the awareness of the villager to training sanitary officials seemed to have yielded positive results to the medical officials. Reporting on the public health of the Straits Settlements, the Director of Medical Services, R. D Fitzgerald claimed:

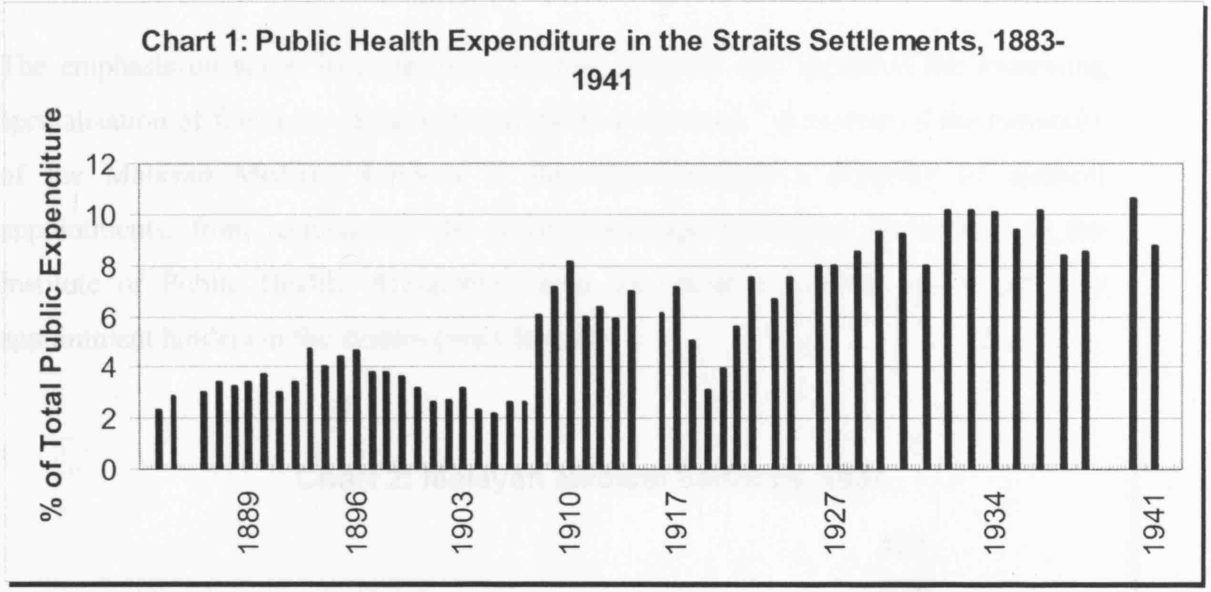
The diffusion of knowledge of the principles of hygiene is gradually spreading amongst school children through lectures and by demonstrations and physical examinations carried out in the schools, amongst mothers through the visit of the health sisters and amongst the population generally through the gradually awakening intelligence of those who share in the advance of sanitary progress. The householder who is unaware of the existence of a sanitary inspector is now a rarity, and few owners are left in ignorance if their holding proves to be a breeding place for mosquitoes.[52]

The Inter-War decades also witnessed a more concerted commitment towards expanding the colonial medical infrastructure and improving the public health of the colony in general. Although expenditure on this area had been steadily increasing since 1908,[53] it was perhaps in the Governor's address in 1920 which reflected the heightened interests by the government.

We have been wonderfully fortunate up to now. The Principal Medical Officer reports that handicapped though we have been by the shortage of staff, the colony may be congratulated by the comparatively good state of public health and on its freedom from any serious epidemics of infectious disease. But we cannot bank on our luck. We must set our house in order. We are still short of skilled staff and in spite of all our efforts it is proving extraordinarily difficult to obtain in sufficient numbers the men that are wanted for organisation, for investigation, for cure of diseases. Our hospitals are not adequate in accommodation or fully equipped on modern lines. Works on sanitation are urgently needed. The toll taken by malaria in life and health is far too high.[54]

[52] *SSMR*, 1931. p. 19.
[53] No recorded evidence was presented to explain for the sudden increase in medical expenditure for that year.
[54] *SSAR*. No. 35 Monday 25 October 1920. Address by Governor to Legislative Council. p.C150.

The expansion of the colonial government's public health infrastructure is reflected in the Straits Settlements medical expenditure in Chart 1 below:



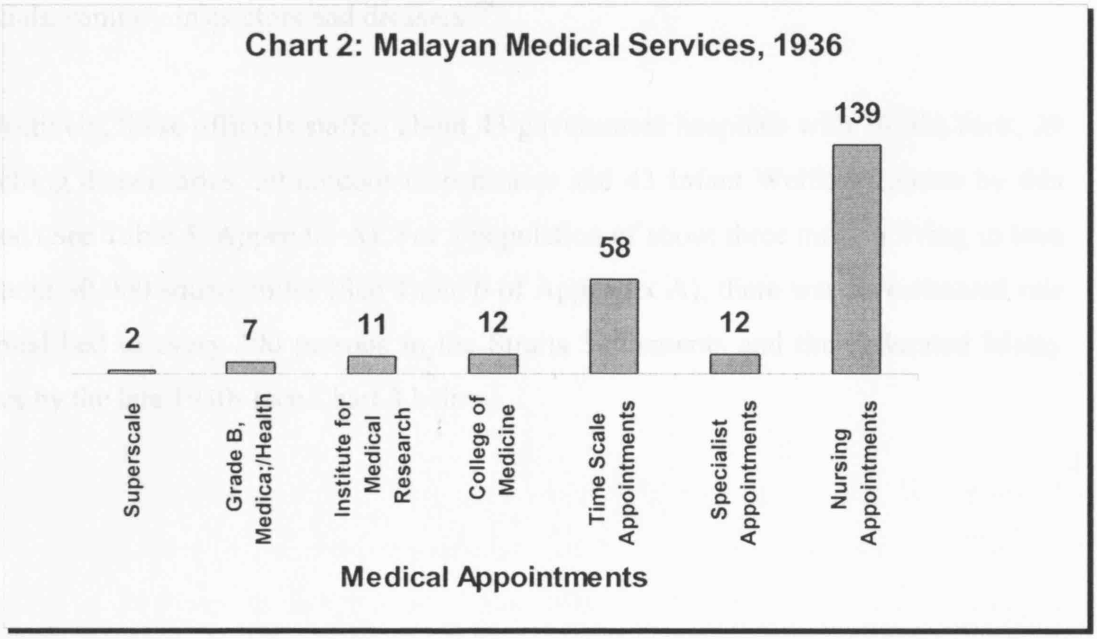
Source: Compilation of *S.S.A.R.* from 1883-1941. See Table 3 in Appendix 1 of Annex A for detailed Breakdown.

The commitment of the colonial administration could be reflected in the resources allocated beginning from a modest two percent in the 1880s to about ten percent of the total public expenditure in late 1930s. From between $300,000 to $500,000 Straits Dollars, spending for building and maintenance of hospitals increased beyond a million in 1920. In the decade between 1927 and 1937, the average expenditure reached about triple the amount before reaching its peak at $5,000,000 in the late 1930s. These ten years also witnessed the heightened spending on general public health, signalling the greater emphasis towards preventive rather than curative measures.[55] By 1926, "health" expenditure overtook that of the "medical" component, and in several years subsequently, the difference in spending amounting to about $300,000. Simultaneously, "social hygiene" appeared as a new category in the public health expenditure of the Straits Settlements in 1928 with an initial outlay of about $98, 620 (see Table 3 in

[55] The preventive measures were further expanded beyond the scope of the medical authorities as the government embarked on more comprehensive public housing projects to replace the more limited measures of improving hygiene and sanitation in the slums of urban area. In 1926, the Singapore Improvement Trust was established and among its first task, was the acquisition of large areas of urban Singapore for building new public houses. *S.S.A.R*, 1926. Address by Governor to the Straits Settlements Legislative Council. 11 October 1926. p. C366.

Appendix A).[56] This section of the budget most probably catered for the venereal disease wards established in government hospitals as well as clinics along the Singapore harbour for sailors in addition to the distribution of social hygiene literature.

The emphasis on social hygiene as a separate category also signalled the increasing specialisation of functions of the colonial medical services.[57] A review of the hierarchy of the Malayan Medical Services in the 1930s reveals a diversity of medical appointments, from lecturers in the Medical College to clinical researchers in the Institute of Public Health. Altogether, there are about a hundred senior and key appointment holders in the system (see Chart 2).



Source: Source: *Annual Report of the Medical Department, Straits Settlements and the Federated Malay States*, 1936, pp. 902-03. See Table 4 in Appendix 1 of Annex A for details.

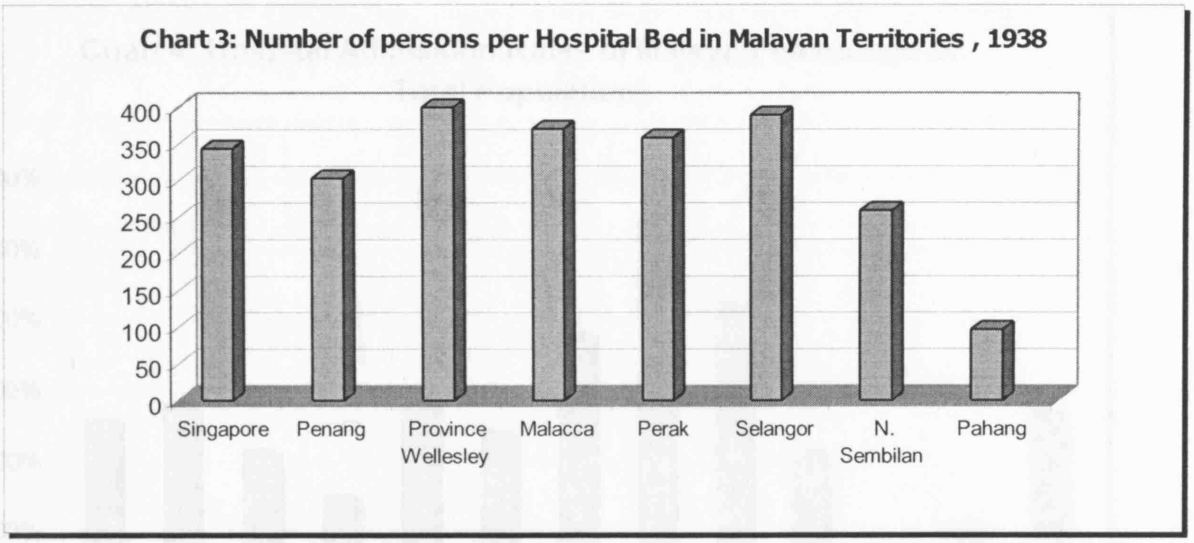
[56] The Social Hygiene Branch was established in 1925 with two full-time European Medical Officers and a number of Assistant Surgeons and junior medical staff. The Branch was tasked with the responsibility of setting up clinics and distributing public health literature. *S.S.A.R*, 1925. p. 37.

[57] Lee Yong Kiat undertook some studies on the development of medical specialisation in colonial Singapore. See: "Nursing and the beginnings of Specialised Nursing in Singapore", *Singapore Medical Journal.* 46.11 (2005): 600-9, and, -"A Brief Introduction to the Evolution of Medicine as a Speciality in Singapore", *Singapore Medical Journal* 46(8): 372-6.

It was however the medical infrastructure they oversaw that enables a more quantifiable appreciation of the influence of colonial medicine on indigenous society. In 1932, the professionally, administratively and geographically scattered medical and public health establishment was centralised under the Malayan Medical Services. Although the Unfederated Malay States were not included, this centralisation was aimed at consolidating the medical hierarchy to facilitate the flow of resources between the various administrative entities.[58] At the eve of the 1942 there were 841 registered medical practitioners in Malaya of which 295 were European and 546 of Asian origins. Of locally trained doctors, 97 were located in the Straits Settlements, 75 in the Federated Malay States and 46 in the Unfederated Malay States.[59] In addition, there were about 2,000 non-professional medical personnel including nurses, public health officials, sanitary inspectors and dressers.[60]

Collectively, these officials staffed about 43 government hospitals with 10,066 beds, 29 travelling dispensaries, 59 outdoor dispensaries and 43 Infant Welfare Centres by this period (See Table 5, Appendix A). For a population of about three million living in area of about 30,000 square miles (See Table 6 of Appendix A), there was an estimated one hospital bed to every 300 persons in the Straits Settlements and the Federated Malay States by the late 1930s (see Chart 3 below).

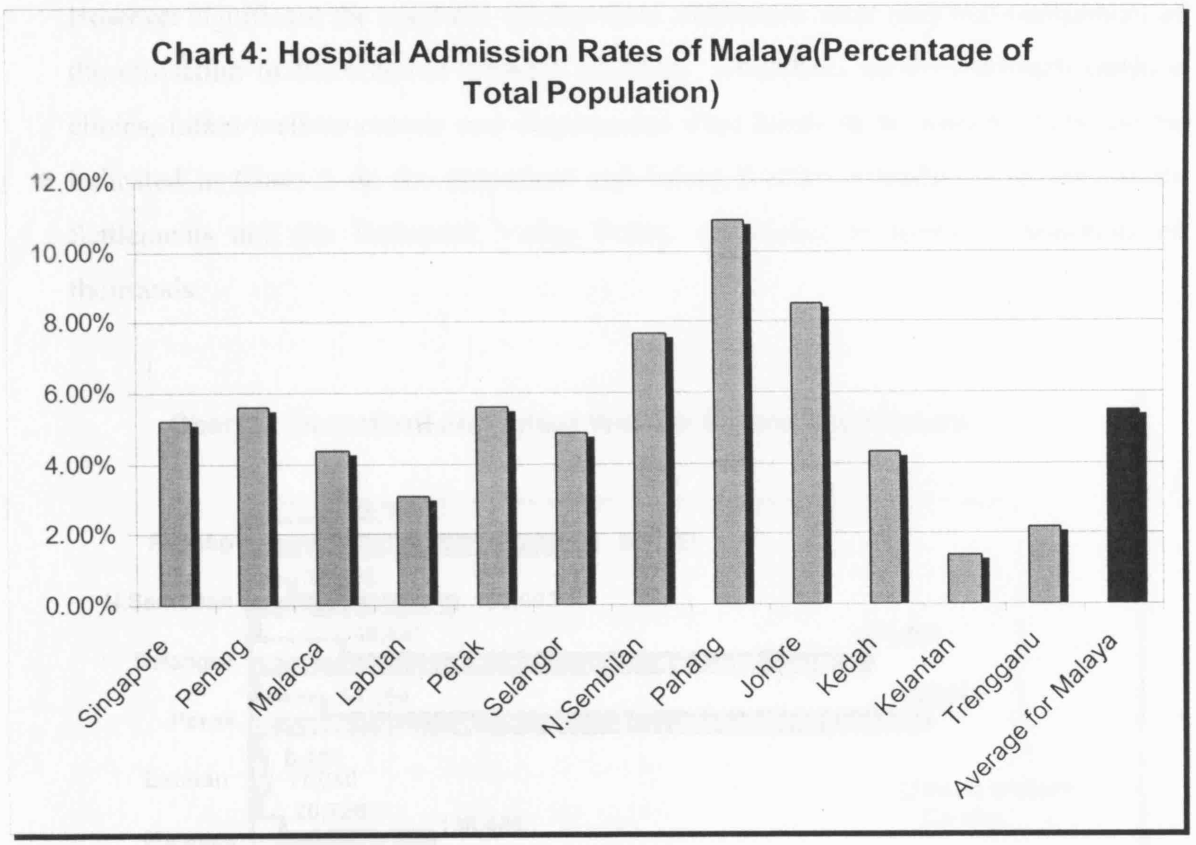
[58] *S.S.A.R.* 1936. p. 901. It was only by the late 1930s that a joint report of the Malayan Medical Services of both the Straits Settlements and the Federated Malay States was introduced.
[59] PRO/CO273/662/5. "Memorandum on the state of public health in Malaya,1939".
[60] Ibid.



Source: Compilation of data from *SSAR*, 1938, pp. 904-909See Table 5 in Appendix 1 of Annex A for details.

The distribution of medical officers in the Unfederated Malay States was however comparatively more scattered than the two political entities discussed, especially in the cases of the Northern Malay States where there were only about twelve medical officers serving about a million residents within 14,000 square miles (see Table 7 in Annex A).

Another indication of the scope of state medicine in British Malaya can be shown in the extent of utilisation of medical and public health facilities in the colony. Chart 4 provides an overview of hospital admission rates in the territories of the Malayan Peninsula during the 1930s.

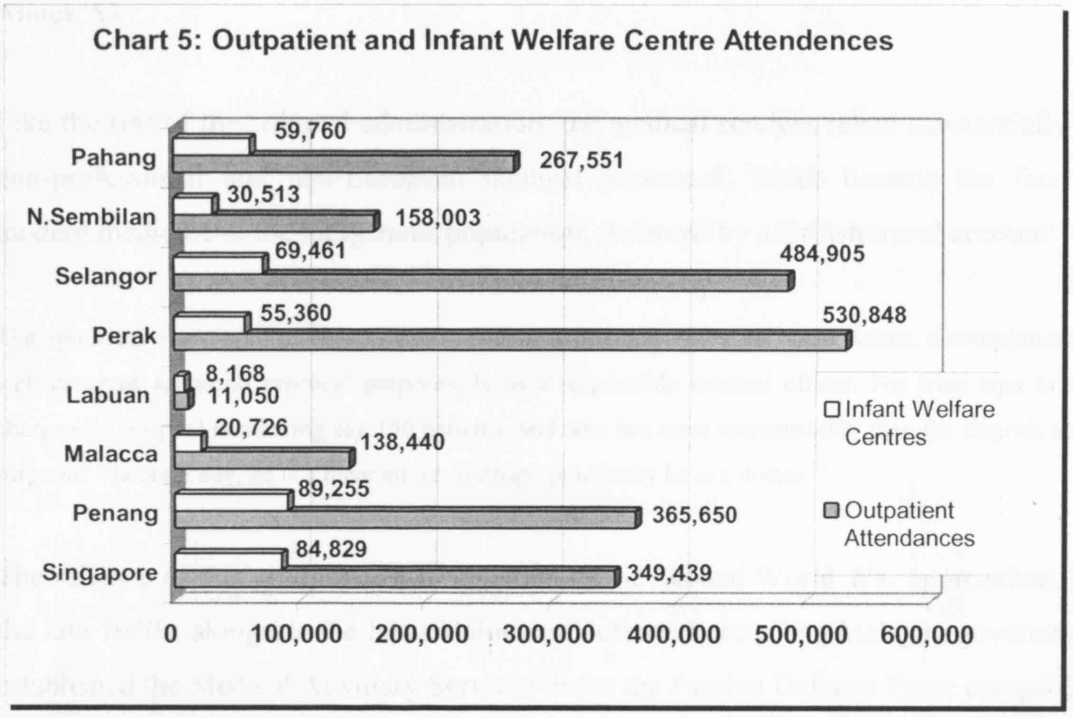


Source: PRO/CO273/662/6.Memorandum on the state of public health in Malaya Medical Report 1939. See Table 8 in Annex A for details.

For an estimated population of five million, the admission rate to government hospitals stood at around 5.5 percent by 1939. These rates were higher in the Federated Malay States at 6.1 percent and the Straits Settlements at 5.2 percent of the population compared to 5.0 percent of the Unfederated Malay States.[61] With the exception of Pahang, it can generally be observed that the more prosperous, populous and established settlements like Singapore, Perak and Johore had higher hospital admission rates than their counterparts in the Northern Malay States of Kelantan and Trengganu (see Table 8 of Appendix A).

[61] This figure does not include inpatient admissions in the various mental asylums and Leper settlements in the colony. From the Malaya Medical Report of 1939, the mental hospitals within the Federated Malay States registered a total of 3,119 patients and the Straits Settlements, 1,739. In the Unfederated Malay States of Johore and Kelantan the figures were 825 and 58 respectively. As for Leper settlements, there were about 1,259 in the Pulau Jerejak Settlement in Penang, 337 in Singapore, 2,357 at the Sungei Buloh colony, 145 in Kuala Lumpur, 347 in Johore and 19 in Kelantan. PRO/CO273/662/6. "Memorandum on the state of public health in Malaya Medical Report 1939."

However significant the numbers, the inpatient admissions were only one component of the utilisation of the colonial medical facilities. Outpatient services through outdoor clinics, infant welfare centres and dispensaries were found to be popular. This can be indicated in Chart 5 on the outpatient and Infant Welfare attendances in the Straits Settlements and the Federated Malay States, numbering in terms of hundreds of thousands.



Source: *S.S.A.R.. 1938. See Table 9 in Appendix 1 of Annex A for details.*

These outdoor medical provisions were predominantly staffed by Asian junior health officials, trained with basic nursing and medical skills who served about 300,000-500,000 clients a year by foot, motor vehicles or riverboats. As the District Surgeon, Dr. Braddon reported a few years after the implementation of travelling dispensaries, this out-door treatment is a direction in which "the usefulness of hospitals to the natives can and should be extended. And their attendance as outpatients is the best test and evidence of a growing reliance upon European medication."[62]

[62] *Selangor Annual Report. 1890*, p. 5.

Table 10 of Appendix 1 of Annex A highlights the extent of the projection of such non-hospital "outdoor services" in Penang. Opened for at least 270 days a year, these dispensaries managed to cover a wide range of patients of different classes. Like the outdoor dispensaries, the vaccinators managed to reach about half a million subjects throughout the Malay States. Between 1924 to 1927, the total number of vaccinations performed in the four states skyrocketed from 78,407 to 269, 509 with the highest proportions registered in the populous state of Perak (see Table 11 of Appendix 1 of Annex A).

Like the rest of the colonial administration, the medical services relied substantially on non-professional and non-European medical personnel, which became the face of modern medicine to the indigenous population. As noted by a British travel account:

> The apothecary-in-charge of an outstation hospital is also known as the Tuan doctor, a compliment he well deserves for to all practical purposes, he is a responsible medical officer. For what man in sole charge of a hospital numbering say 150 patients, and who has more responsibility than the English home surgeon? Theoretically, he is a mere mixer of drugs, practically he is a doctor.[63]

The reliance of this group was also apparent as the Second World War approached. By the late 1930s, alongside the local Volunteer Defence Forces, the Malayan government established the Medical Auxiliary Services under the Passive Defence Force comprising by 1942 3,000 personnel.[64] Receiving basic medical and civil defence duties, the quasi-military force of volunteers provided first-aid and ambulance services during the Japanese invasion of the colony in December 1941.[65]

"Describing affliction": State Priorities over Diseases

The categorisation of diseases by the colonial medical authorities in Malaya did not begin with a fixed template as shown in the rather undifferentiated ideas of illness in the pioneering years of British rule. During the early 19th century, East India Company

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[63] John Robson. *People in a Native State* (Singapore: Makepeace, 1894) p. 63. (National Library Board, Singapore: Rare Books Collections).
[64] *S.S.A.R.* 1938. p.845.
[65] See: PRO/CO273/699/10. "The Civil Defence of Malaya: A narrative of the part taken in it by the Civilian Population of the Country in the Japanese invasion." Complied by a committee under the chairmanship of George Maxwell. Published under the Association of British Malaya. 1946.

officials and the early migrants in Penang were thought to be afflicted by a peculiar infection known as the "Pinang fever":

> It is observed to bear the large proportion of one-third of the whole number of ascertained causes of death among the adult residents. The island has long been noted for the very fatal form in which the disease presents itself. So insidious was its approach-scarcely one attacked with it recovering-that it was dreaded by medical men and others as a new and undescribed affection, totally irremediable and distinguished form all other fevers by its uniformly fatal issue.[66]

Before the 1900s, although the instances were low and localised, health officers had kept wary eyes on plague and smallpox. The more chronic cases affecting the various territories were that of cholera, beri-beri and leprosy. There were certain years where epidemics grabbed the attention of health officers like the high incidences of malaria in 1901 and 1911 and the Influenza pandemic in 1918. Otherwise, issues like tuberculosis, venereal diseases and opium addiction surfaced more frequently in the annual reports of the various political entities from the 1920s.

In their accounts, the medical officers concerned had usually a long list of mortality and morbidity rates attributable to individual diseases (see Chart 6 on the general categories of diseases in the Straits Settlements). From hospital admission figures between 1899 to 1929, malaria seemed to be ranked as the most prevalent disease even though incidences of diarrhoea and ulcers were relatively common with low fatality or where the proportion of patients surviving from enteric fever was significantly lower. The cases of venereal diseases and ankylostomiasis or hookworm diseases provided a different picture. In contrast with malaria, the number of registered hospital cases and deaths from hookworm diseases was mild. Admission rates however, shot up by more than one hundred percent over the decades, probably causing some alarm and diversion of resources to address such trends.

It was only by the 1930s that the colonial medical services had four categories of diseases which could be ranked either in importance or treated separately between endemic and epidemic in other occasions.[67] The first, "General Diseases" referred to

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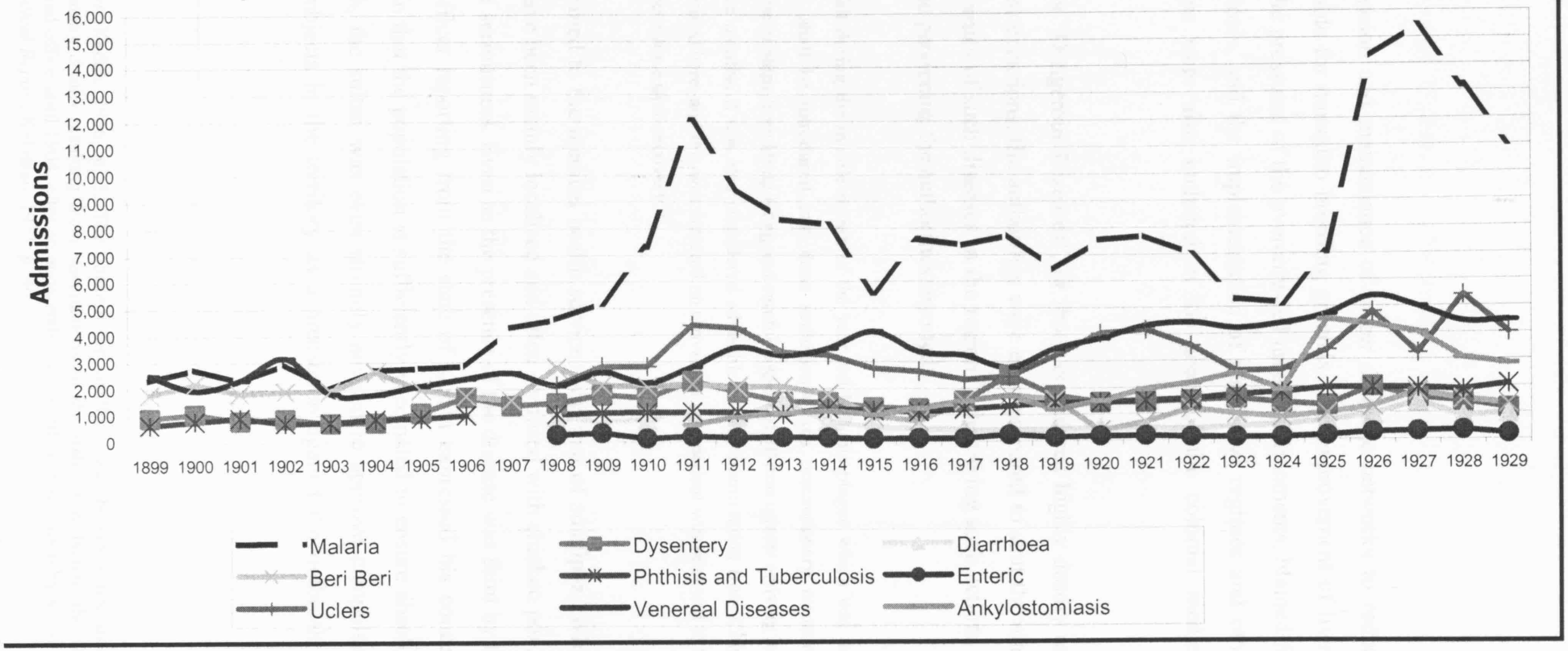
[66] Chai Hon-Chan. *The Development of British Malaya;1896-1909* (London, Kuala Lumpur: Oxford University Press, 1964) pp.216-7.
[67] *SSAR*. 1932. p. 903.

endemic diseases like pneumonia, beriberi, dysentry, malaria and tuberculosis. Accounting for the highest numbers of hospital admissions and death rates, these were problems to be tackled with sustained preventive health measures.

Chart 6: Hospital Admissions in the Straits Settlements based on Diseases, 1899-1929



Source: Compilation of *S.S.A.R.* from 1899-1929. See Table 12 of Appendix 1 of Annex A for details.

This covered the provision and maintenance of larger drainage networks to reduce stagnant water favourable for mosquito breeding grounds. The improvement of living conditions alleviated the pressures of the overcrowded urban environments, blamed for the spread of tuberculosis, and the implementation of nutritional regimes and other public health messages were also included in the goals of the colonial medical services.[68]

The next category was "Dangerous Diseases", or those considered highly deadly and contagious. On several occasions, the authorities were even prepared to shut the main ports on news of epidemics of such diseases in the region.[69] Justifying such actions in 1894 against the plague pandemic, the authorities reported:

> Some apprehension was felt during the middle month of the year lest bubonic plague which was then epidemic in Hong Kong, shall be introduced into these settlements, and precautionary measures, including one day quarantine of ships from Hong Kong and careful inspect of all immigrants arriving here were taken. For some three months, it was also considered advisable to stop immigration from China. Only one case of plague arrived here, and this was detected on arrival. and the patient was removed to the quarantine station, where he made a slow recovery.[70]

The main worry it seemed to the medical health services was that of smallpox. While the outbreaks might have been mainly localised and often confused with chicken pox, it was taken with utmost seriousness. Even as the presence of the disease was faint by the 1930s, the medical officer reporting from the state of Kedah expressed his concern where "it is not certain that the population is sufficiently vaccinated to ensure absolute protection."[71] As such, the sultan was even strongly advised to approve compulsory vaccination for his subjects in the territory as a precaution against the outbreak of smallpox.[72]

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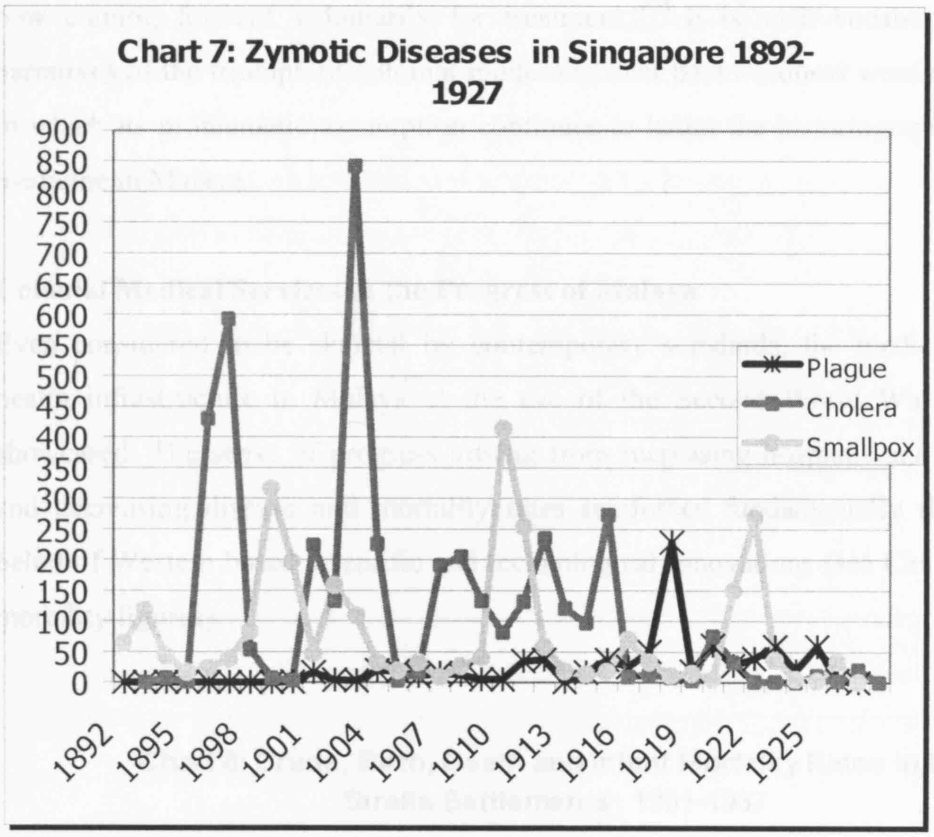
[68] Ibid.
[69] Ibid.
[70] *S.S.A.R,*. 1894. p. 18.
[71] *Annual Medical Report*. Kedah. 1936, p.15. The concern for smallpox was however not shared universally. Due to the many deaths resulting from vaccinations in the state of Kelantan. the state declared the practice a penal office until 1904, after an apparently successful demonstration by a visiting British doctor. *Annual Medical Report*, Kelantan. 1921, p. 46.
[72] Ibid.



Source: Source: *SSAR*, 1927. p.737. See: Table 13 in Appendix 1 of Annex A for details.

Judging from Chart 7 above, the prevalence of these zymotic diseases registered a general decline with plague almost disappearing from the island by the 1920s. Nonetheless, as revealed in their high mortality rates of those infected, and the potentially apocalyptic rapidity of infections, these diseases continued to be closely monitored (See Table 13 in Appendix A for mortality rates for these diseases).

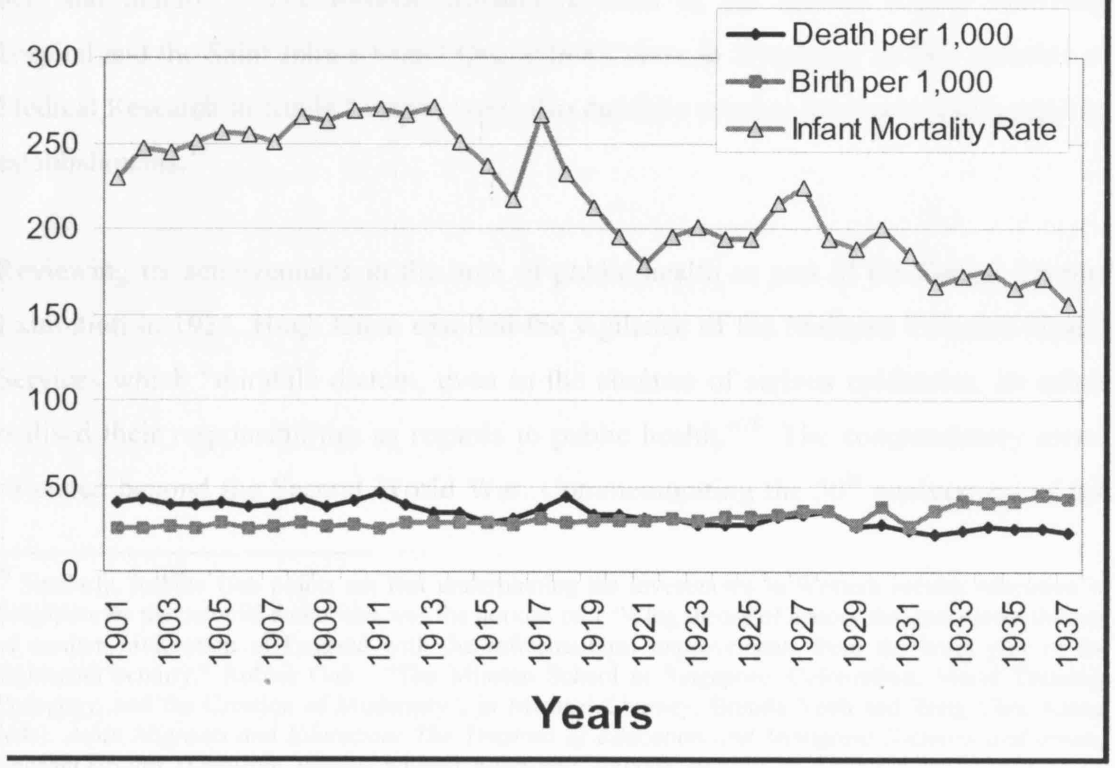
Infectious diseases of a lesser potency to the colonial medical services like venereal diseases and yaws were ranked in the third and fourth tiers. Despite their prevalence, these diseases were considered to be containable in the long term. In fact, the colonial medical services had credited their vaccination and public health efforts for seemingly eradicating yaws in the colony. Noting the success, in the treatment of yaws, the medical authorities for the Straits Settlements reported that the preventive measures "led to present faith in Asiatics particular among Malays in hypodermic and intravenous injections. The rapidity of and certainty of cure has impressed the natives and they are

now coming forward voluntarily for treatment."[73] It is such vocabularies that the narratives of the triumph of colonial modernity over backwardness were founded upon, in which its problematic assumption continues to haunt the historiography of colonial medicine in Malaya.

Colonial Medical Services & the Progress of Malaya

Even considered to be skeletal by contemporary standards, the medical and public health infrastructure in Malaya at the eve of the Second World War was proudly showcased. The sense of progress arising from increasing hospitals and medical staff and decreasing disease and mortality rates reinforces fundamentally the triumphant belief of Western based scientific and technological innovations (see Chart 8 below for mortality figures).

Chart 8: Crude, Birth, Death and Infant Mortality Rates in the Straits Settlements , 1901-1937



Source: *S.S.A.R*, 1937, p. 182 See Table 14 of Appendix 1 of Annex A for details.

[73] *S.S.A.R*. 1932. p.902.

From autobiographical accounts to formal dinners and commemorations, the British in Malaya ritually credited themselves for civilising the indigenous population. The narrative of public health in the colony was one of persistent application of modern medicine in an anarchic and malarial terrain.[74] Recounting his years as being one of the pioneers of the British protectorate in the Malay States, Frank Swettenham wrote:

> The Malay sultans and chiefs who are here today will bear me out in saying that we have faithfully and earnestly endeavoured to fulfil the somewhat difficult task we then undertook. The condition of all the people of the Federated Malay States has improved, step by step, with the advancement of the country form roadless jungle to railways, telegraphs, schools, hospitals and the other accompaniments of scientific administration. The Malays have in all this been great gainers.[75]

Particularly, praises were showered upon European medical practitioners of the colonial health services for their tireless determination in carrying out curative and preventive health work. Individual health officers like Hamilton Wright, Robert Fletcher and Malcolm Watson were extolled for making blazing trails into tropical diseases like beri beri and malaria.[76] The medical institutions such as the Kerbau Kebau Maternity hospital and the Saint John's Island Quarantine Centre in Singapore and the Institute of Medical Research in Kuala Lumpur were also dutifully rated as internationally premium establishments.[77]

Reviewing its achievements in the area of public health as part of the British Empire Exhibition in 1924, Hugh Gunn extolled the vigilance of the Malayan Colonial Health Services which "mirabile dictum, even in the absence of serious epidemics, its rulers realised their responsibilities as regards to public health."[78] The congratulatory mood extended beyond the Second World War. Commemorating the 50th anniversary of the

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[74] Similarly, Robbie Goh points out that underpinning the investments in Western secular education in Singapore by the colonial authorities was the notions of a "Whig theory of history that associated the rise of modern civilisation in England with the infrastructural improvements from the latter part of the eighteenth century." Robbie Goh. "The Mission School in Singapore: Colonialism, Moral Training, Pedagogy, and the Creation of Modernity", in Michael Charney, Brenda Yeoh and Tong Chee Kiong (eds). *Asian Migrants and Education: The Tensions of Education and Immigrant Societies and among Migrant Groups* (Dordecht, Boston: Kluwer Academic, 2003) p. 29.

[75] Robert Heussler. *British Rule in Malaya; The Malayan Civil Service and its predecessors, 1867-1942* (Westport, Connecticut: Greenwood, 1981) p. 18.

[76] See: J.W. Field, R. Green and F.E. Byron. *The Institute for Medical Research, 1900-1950* (Kuala Lumpur, Malaysia: Government Press, 1951).

[77] C.W. Hutt. *International Hygiene* (London: Methuen, 1927) pp. 47-48.

[78] Andrew Balfour and H.H. Scott. *The British Empire. Vol 5: Health Problems of the Empire and their Development* (New York: Henry Holt & Company, 1924) p.147.

establishment of the Institute of Medical Research, J.W. Field, who was a health officer prior to 1942, reiterated:

> Today the medical resources of the main towns in Malaya are probably comparable in their range and standards with the resources of the smaller towns in the United Kingdom. The hospitals provide a comparable range of facilities for medicine, surgery, radiology, obstetrics, pathology, and special services. There are clinics for infants and mothers, for school children, for dental care and vaccination and for the treatment of special diseases. The ideas and methods of social medicine are beginning to grow...[79]

Manderson notes such tributes to part of the undercurrent attempts by the colonial administrators to justify their presence and reify their legacies in the colony where:

> Sickness provided a field for cultural colonialism; the political economy exposed, and often caused health problems; the state had the knowledge, institutions and technologies to prevent and cure them. The incorporation that occurred here with the extension of medical and health services was both intellectual and institutional; sanitation programs, public health acts, rural extension work and health education all served to legitimise the state and give to it a moral authority that derived from the valourisation of science. [80]

However, it seems a general consensus has been crystallised on the state as the spearhead of not just modern medicine, but also colonial medicine, with the officialdom imposing changes upon societies concerned. But, this assumes a single minded, well-oiled bureaucratic machinery in operation. The historical state on the contrary, could have reacted differently.

The Limitations of *Obat Bahru (New Medicine)*

These celebratory impressions, however portray the reach, instead of the boundaries of colonial medicine, which can be explored along three interrelated angles. They are namely, the difficulties faced by the medical bureaucracy, the response of the populace, and, more importantly, the alternative or supplementary provisions by non-state agencies. Divisive and fumbling officialdoms as well as defiant clients of public

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[79] J.W. Field, R. Green and F.E. Byron. *The Institute for Medical Research, 1900-1950.* pp. 34-35. Similarly, a mission of the international bank of Reconstruction and Development which visited Malaya in 1954, described the health situation as one of the world's outstanding achievement of public health and medicine, a tribute to the British administrators and their medical and public health officers. Phua. *The Development of Health Services in Malaya and Singapore.* p. 9.

[80] Manderson. *Sickness and the State.* p. 242.

institutions have conventionally attracted historiographical attention, including that of state medicine. For the case of British Malaya, the issues within the medical services reflected the broader institutional difficulties faced by the colonial administration. Differences in the attitudes of senior medical officials aside, there were three fundamental and perennial problems facing the development of the Malayan medical services.

Perhaps a glimpse into the factional and bureaucratic rivalries can be revealed through the diaries of IHB's Victor Heiser. During his visit to Malaya, several senior health officials confided in him their dissatisfactions on the state of the colonial medical services. Heiser recorded the complains of Dr Dowden, the Principal Medical Officer, on how his work was systematically retarded by the Chief Secretary of the Federated Malay States, George Maxwell who was portrayed to be paranoid about losing central control. Another grouse came from a more junior official,[81] A.R. Wellington, that the "medical service had no discipline and organisation was miserable."[82] Unlike Dowden's, Wellington's grievances aroused from the obstructions faced in public health work from the British Residents in the Malay States who wielded considerable authority.[83]

Underlying the personal grievances were the difficulty in attracting medical professionals from Britain into the territory, [84] the competing priorities between "medical" (curative) and "preventive" (public health) works,[85] and more importantly, the negotiating of hierarchies between state and federal authorities.[86] The negotiations

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[81]RAC/RG.12.S. 12.1, Box 27 Officer's Diaries: Heiser's Diaries, 20 January 1926.
[82] Ibid.
[83] Ibid.
[84]As lamented by the report on the Medical Department of the Federated Malay States in 1905: "The staff is not always at full strength owing to sickness and absence on leave. The district surgeons, in addition to their strictly medical duties, have to give up a great deal of their time to administration work, accounts, statistics and reports-matters which in large institutions in England are left to lay staff. Under such circumstances, it is doubtful whether however zealous and capable they may be, and assisted as they are by Eurasian apothecaries and dressers, they can allow sufficient time for the proper diagnosis and treatment of each of the large number of cases committed to their charge." *A.R.F.M.S.* 1905. pp. 15-16. As the Governor of acknowledged in 1920, "Institutional medical requirements of the colony receiving attention and government bringing medical staff up to strength". *S.S.A.R.* No. 35 Monday 25 October 1920. Address by Governor to Legislative Council p. C151.
[85]This issue was resolved in 1920 with the announcement by the governor of the separation of the medical department into the medical and public health branches in 1920 with the creation of the posts of a Chief Sanitary Officer and Chief Health Officer. Ibid. p. C150.
[86]PRO/CO882/10: "Policy of Decentralisation and Constitutional Reorganisation in the Federated Malay States." Eastern No. 142, May 1925. See also: George Maxwell: "Observations upon the constitution of

between medical, civil and political authorities created a more confusing picture as demonstrated in the findings of a Medical Enquiry Committee on the Federated Malay States in the aftermath of a move to decentralise the civil service in the 1920s.

[After decentralisation, the] Medical department of each state now becomes an independent unit confined to the state. In the present condition of flux it seems that the Senior medical officer of each state is responsible for the efficient management of his state medical affairs and he can only refer to the Resident only in times of difficulty; The Resident in turn may refer to the Chief Secretary or may ask the advice of the Principal Medical Officer[...]The splitting up of the department into smaller units, each unit acting under lay control, and in which the only co-ordinating influence is through a higher lay control with or without the advice of the medical advisor, is the most disturbing and in the opinion of the committee, the most disintegrating element in the scheme of decentralisation. Years ago, it might have been accepted with compliance, but such has been the advance of knowledge in recent years that even medical men, who have not made strenuous efforts must fall behind. An intelligent comprehension cannot be expected of the laity. The inability of the layman to recognise the good work done, the nebulous position of the Medical Officer in each state as to promotion, leave and allowance and the absence of any responsible medical head would soon reduce medical practice to a domestic practice.[87]

Collectively, these problems underlined the structural obstacles of the colonial regime in effectively governing its far-flung territories with differing political arrangements.

Adding to these growing pains was the geographical expanse accompanied by the socio-cultural indifference or suspicion of the indigenous and immigrant population towards government institutions. Mandatory medical examination and vaccination and quarantine measures enabled a wider screening process. But, efforts to foster a more popular acceptance of Western based state medical facilities and practices were significantly less successful. Even with the spread of the colonial medical infrastructure, the geographical access for the bulk of the population remained far off.

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the Federated Malay States with particular reference to the policy of Deceentralisation and the Appointment of the Chief Secretary to government". PRO/ CO717/45. No. 28643 24 July 1925.

[87] PRO/CO717/48. Federated Malay States: Medical Enquiry Committee, 1925 (D.J. Galloway, Watson,A.L Hoops and R.DFitzgerald) p. 3.

To begin with, the actual collection of data, particularly on health statistics, remained difficult on several grounds. Returns on morbidity and mortality were mostly obtained from government hospitals or police stations. With the exceptions of the larger agriculture estates and urban centres, such institutions remained largely inaccessible to the local population, especially those from the rural and poorer sections. In addition, whether by design or default, it was commonly believed that the statistics on mortality rates and other epidemiological figures were often grossly underestimated.[88] Similar stories of inefficiencies were also apparent in what was considered as the "optimal" utilisation of medical facilities by its clients. In the report of the Medical Department for 1906, the medical authorities in Perak lamented: "It is to be regretted that the Malays take little advantage of the facilities for treatment offered to them in this way; they welcome treatment at their own homes, though they do not always conform to the directions given to them, but they will not, with few exceptions go to the hospitals for treatment."[89] Although these limitations were not peculiar to British Malaya (and still prevalent in contemporary societies), they underline a less idealised or complete representation of the colonial state.

While the discourses of local "resistance" towards colonial medicine may not entirely describe the experience of the various ethnic groups in British Malaya, the response was not one of sheer enthusiasm either. Government hospitals and medical facilities received mixed reactions and selectively were appropriated by different groups. An ethnic Indian doctor recalled the enthusiasm with the opening of a hospital in the 1920s:

> Obat Bahru (new medicine) as the Malays called it, spread far and wide through Perak, and other Malay States from Kedah to the Straits Settlements[...]A hundred to hundred and fifty on average daily number of those who flocked to Kuala Kangsar hospital, arriving by road and rail. One could see a string of people of all ages and conditions walking in a continuous stream, from the railway station to the hospital, a distance of half a mile.[90]

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[88] During his visit to Malaya, Heiser claimed that he was told by the British medical official A.R. Wellington that mortality rates in the colony were artificially deflated by about ten percent in order to reveal a less alarming public figure. RAC.RG.12.S. 12.1. Box 27 Officer's Diaries Heiser's Diaries, 20 January 1926.

[89] *FMSAR*. 1906. p. 15.

[90] A.Viswalingam. *Pioneer Preventive Social Medicine in British Malaya* (UK:L Dimbleby, 1977) p. 23

Beneath this fervour, however lay a more complicated picture. Highlighting the differences between the various ethnic groups with regards to seeking medical attention, F.W Field, the Medical Officer of the Malay state of Perak pointed out: "We cannot fairly compare the Indian with his prompt hospitalisation in the early stages of the disease to the Chinese who resorts to hospital only when his native remedies failed, or with the Malay who seeks hospital aid for minor distresses of his race, but elects to be among his own kampong folk in times of serious illness."[91] Among other complaints cited by colonial medical officials were the difficulties in changing attitudes towards hospitals regarded popularly as death houses instead of healing sanctuaries, accepting surgeries or following instructions of prescriptions. Generally attributed to the "ignorant and superstitious habits of the natives", such underutilisation or "misappropriation" reflected again on the limited reach of colonial medicine. The aversion to public health institutions, for example, was not only confined to the general local population, but also European residents in Malaya. As quoted by a frustrated medical official:

> I have in vain urged upon Europeans whom I have been called upon to attend, the advantages of treating their cases in hospitals, where the necessary appliances are at hand, but in instances when I have induced them to enter, the desolate and unsatisfactory conditions of the buildings alone, were enough to drive them away. As one patient expressed himself, "it is as bad as a prison without the life and bustle."[92]

Even with the predominance of government medical services, the mediating roles of non-state agencies should not be neglected. In his observation of the public health of British Malaya in the 1920s, L.R. Wheeler noted:

> The great proportion of all healing and prevention of disease has fallen on the government. However, good work has also been done by missionary bodies like the Church of England hospitals in Singapore and Malacca, and the dispensaries of the Methodist Mission; while in the large towns the Chinese community maintains hospitals and other institutions for the benefit of its nationals within government support. The large European mining and planting interests provide medical aid for their hundreds of thousands of workers, often having their own hospitals, doctors and dispensaries[...]Help is also given by the Rockefeller Foundation and the League of Nations.[93]

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[91] J.W. Field. "Some observations on Vitamin 'A' starvation among immigrant Indians in Malaya" *The Malayan Medical Journal: The Journal of the Malayan Branch of the British Medical Association.* Vol VI. 1931. p. 51.
[92] *S.S.A.R.* 1879. p. 291.
[93] L.R. Wheeler. *The Modern Malay* (London: Allen & Unwin, 1928) p. 265.

The purpose here is not merely to acknowledge the existence of these private and philanthropic bodies or to discover where the state ends and civil society begins. A more complicated task in transcending the state-centric narrative lies also in framing an entangled relationship between the two seemingly neatly separated bodies. Specifically, this involves delving into the extent to which the particular institutions of the colonial medical service in Malaya had either their ontological roots in, or were appropriated from community organisations. Related to this is the need to assess how these provisions complemented or contested that of the state. Finally, such study enables a broader view of the lobbies utilised or created by civil society elements to influence the discourse of state medicine.

The Tropical Gothic Middle Class Aristocracy: Civil society and public health

Aside from the local Malay populace, British Malaya was largely a transient territory for migrant communities attracted to the burgeoning colonial economy. Nonetheless, participation in public affairs surfaced gradually as interested parties felt the need to obtain a greater voice in policy matters. In spite of the absence of a direct electoral representation(whereby executive and representatives appointments were selected rather than voted), civil society groups based on trade and ethnic associations remained relatively influential. As Robert Heussler observes:

> Even if the bureaucracy had been more tightly disciplined than it was, there would still have been a never-ending chorus of comment from businessmen with strong views that they were not shy of expressing. As the 1900s wore on, their voices were joined increasingly by those of Chinese, Malay, and Indian spokesmen, all wanting to be heard and all aware of the freedoms enjoyed by home based Englishmen. [94]

It would be mistaken to define all health lobbies merely as organisations devoted solely to public health issues. They were driven by a broader social spectrum of organisations with overlapping economic interests and moral considerations. Groups took issue with specific diseases, general health conditions of a locality and/or with public health legislations, or the lack of them. In this respect, it was predominantly the more privileged classes within the colonial society who took more active interest in the subjects. The inclusion was based on what Stoler and Cooper describes as bourgeois

[94] Robert Heussler. *British Rule in Malaya; The Malayan Civil Service and its predecessors, 1867-1942* p.228.

civil society, or the *Homo Europeaus* which the British community had transplanted to the colony.[95]

There were three general strategies which these non-state bodies either gave supplementary support or contested the functions of the colonial administration. The first two methods entailed the direct provision of medical facilities, obtaining representatives versed in not just public health issues, but also familiar with the political culture of the colonial government. If the options were neither available nor effective, groups would openly rally a larger public opinion to push for, or challenge public health policies.

The history of public health services in the colony did not start with the first government hospital. The Malay villages were served by local medico-religious healers and midwives, while the immigrant populations especially the ethnic Chinese organised charities and medical halls. Managers of tin mines and rubber plantations provided hospital facilities for the armies of coolies before the British political control was extended to these areas. The first main hospital in the Malay States, the Anglo-Chinese or Yeng Wah Hospital based in Selangor, was financed by Chinese merchant community leader, Yap Ah Loy in 1880.[96] This was followed by his counterpart Loke Yew who funded the building of a small government managed hospital in Seremban, and the Tung Shin hospital by Yap Kwan Seng in Perak which was maintained by Chinese doctors who provided traditional Chinese medical treatment.[97] By the early 20th century, medical missions, philanthropies and international organisations became active in providing medical relief or public health campaigns.

Beside health facilities, civil society groups were also drawn into articulating their interests and grievances through the available official channels. Prior to the 1860s,

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[95] Ann Stoler and Frederick Cooper. "Between Metropole and Colony: Rethinking a research agenda" in Cooper and Stoler(eds) *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley: University of California Press, 1997) p.3.

[96] It was reported that: "The hospitals in the Larut districts are almost entirely charitable institutions, and care is taken to see that only cases really requiring treatment are received. 1,288 patients remained under treatment[...]The Chinese Consul General for the Straits Settlements and the Chinese Consul of Penang, visited some of the hospitals during the year and expressed their appreciation of the system and presented a sum of $200 which has been partly expended in the purchase of Chinese books for the use of patients." *Report on the Protected Malay States*, 1896. p. 29.

[97] Phua. *Development of Health Services in Colonial Malaya*. p.49.

public deputations were made to the authorities, but the process became more formalised by the turn of the century. An important platform for articulating such interests was through the Legislative Councils of the Straits Settlements established in 1867 and its counterpart in the Federal Council of the Federated Malay States. The balance of power within the body was tilted towards government officials who comprised the majority of the assembly and were prohibited from voting against the proposed legislations. Moreover, in spite of the large Asian population in the territory, the representation of the non-official members was predominantly Europeans. Nonetheless, the state was still obliged to openly account for its policies and consider the claims and arguments of the community representatives. [98]

On a more routine level were the various working committees encompassing local officials and community representatives. More than just seeking consultation and technical advice, they provided the platforms for their policies to be mediated and legitimised. In the urban centres of Penang, Malacca and Singapore, the Municipal Commissions played the advisory roles to the municipal authorities. A similar arrangement was set up in the Federated Malay States where districts were being generally advised by the local Sanitary Boards. These committees served to refine public health policies as well as addressing disputes on a wide range of urban health issues, especially on waste disposal, sanitation and drainage. As with other areas, the colonial state sought expert opinion and general consensus on more contentious issues. Among the more functional committees were that of Malaria Advisory Committee charged with improving preventive health across in the Peninsula. A larger attempt to incorporate different plantations to share the financial burdens and collective responsibilities in conducting public health work in common areas and setting up estate hospitals came in the Local Agricultural Boards. Government committees on the more controversial matters like social hygiene and opium consumption were also set up resolve political differences among contending groups.

Not merely confined to the official forums, significant discussions on public health policies took place in the public sphere. Unlike government committees, the open discussions of health issues were meant to raise larger social consciousness and support

[98] Grace Chia. *Asian members of the Straits Settlements Legislative Council, 1908-1941* (Hons Thesis: National University of Singapore, 1960).

for change. In her study on colonial civil society in Singapore, Kay Gillis demonstrates the mobilisation of civil society networks in challenging the state in a petition by merchants against port dues:

> The action by the mercantile community of Singapore became the standard method of influencing policy decisions in their favour. The merchants called a public meeting that was given maximum publicity in the local press. This was followed by the drawing up of a petition to be sent to the appropriate government authorities and finally, the rallying of support from influential friends in London, and to be effective, the group of merchants needed to provide pressure directly at the centre of the decision making process.[99]

One method was through the organisation of public meetings and lectures in venues provided in Town Halls, churches and hotels.[100] While such meetings served a more general audience, other gatherings also catered to specific interests and groups. For example, lectures on drainage and malaria were often attended mostly by plantation managers, while discussions on social hygiene by women and opium addiction by the ethnic Chinese community. Usually, such meetings would end in resolutions and petitions for the government to rectify the problems concerned.

A more common platform for the participation of civil society in the matters of the state in British Malaya was the local newspapers. As would be highlighted in subsequent chapters, the print media was instrumental in moulding the attitudes of public opinion on issues concerning public health. While the first publications could be traced to the early 19th century, the newspaper culture blossomed by the turn of the century with more dailies established in the Malayan Peninsula following the expansion of economic interests and population growth. Initially serving business interests in providing shipping news and other advertisements, these newspapers became foci of public discussions.[101] Until 1942, there were approximately eighty English and vernacular newspapers with the main dailies based in the prominent urban centres in Singapore,

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[99] E. Kay Gillis. *Singapore Civil Society and British Power*. p.29.
[100] Carl Troki. *Singapore*. pp.44-5.
[101] For more details into the history of newspapers in Malaya, see: C.M Turnbull. *Dateline Singapore: 150 Years of the Straits Times* (Singapore: Times Edition, 1995), Chen Mon Hock. *The Early Chinese Newspapers of Singapore, 1881-1912* (Singapore: University of Malaya Press, 1967), Ampalavanar Kanayson,. *The Newspapers of Singapore, 1824-1914* (University of Malaya, Singapore: Honours Thesis, 1958), Trocki. *Singapore*. pp.66-9.

Kuala Lumpur, Ipoh and Penang.[102] Aside from the general media, there were also more specialised journals and magazines catered for different interests, but these also carried articles and commentaries on public health issues in the colony.

These ranged from the *Malayan Branch of the Journal of the British Medical Association,* with medical articles contributed by the medical fraternity in the territory, *The Planter*, a quarterly journal for plantations managers and owners, the *Straits Chinese magazine*, and *British Malaya*, a monthly journal published for the British readers who had lived in the colony. Financed and subscribed by the more literate merchant communities, the opinions of especially the daily newspapers reflected substantially on the liberal ethos of market economies. The editors and journalists also held a passionate belief of a strong civil society manifested through an independent press as the voice of the community and to check against the state. Several English language newspapers editors had in their debut publications, embraced these ideals as their mission statements. The *Times of Malaya*, a paper closely linked to planting interests, for example proclaimed:

> The press in most countries, is the right arm of defence of the people. Through it their grievances are aired, tyranny, and every species of oppression is exposed, intolerance, injustice, and corruption fearlessly denounced, and the inalienable right of all free born men to equality of treatment and to be left in peace to earn an honest livelihood stoutly maintained.[103]

An early edition of the *Malay Mail*, based in the Federal capital of Kuala Lumpur had also assumed the role of being the watchdog against state power as its core purpose:

> Federal officials[...]naturally preferred to carry on the administration behind closed doors. They were not anxious to have people asking unpleasant questions. Mistakes are occasionally made in administration and the less talk about them, the better. A man who has wielded excessive personal power for many years does not relish having his proposals subjected to public criticism. An official lifetime in the East does not tend to keep the official mind in touch with the liberal traditions of England. In principle we want more publicity and a proper channel from conveyance of ideas between the government and people in practice.[104]

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[102] The prominent newspapers in Singapore were: *The Straits Times*, *Singapore Free Press* and *The Malayan Tribune*. In Kuala Lumpur, it was the *Malay Mail*, in Perak, The *Times of Malaya*, and in Penang, the widely circulated English dailies were *Straits Echo* and *the Penang Gazette*.
[103] *The Times of Malaya* (Henceforth known as *TM.*) 4 November 1907.
[104] *Malay Mail* (Henceforth known as *MM.)* 27 April 1904.

While the colonial medical services were mainly devoted to curative and preventive health, it was the newspapers that provided the information and the educational aspects. By relaying news of epidemics outbreaks in the region and around the world, it was responsible for mapping the disease geographies. Until the establishment of the League of Nations Epidemiological Station in Singapore in 1925, the colonial medical services were reliant on the newspapers to track the international patterns of infectious diseases. Added to this, it also propagated the understanding of modern medicine by featuring articles regarding the trends in medical knowledge through lectures, reports and stories. This placed not only the colonial services under greater scrutiny, but also amplified debates and grievances of individuals and organisations as well.[105]

Participation in health politics on these platforms of committees, media, and town hall meetings were confined largely to the more literate, privileged and organised. To be represented or heard, lobbyists were required to be familiar with the claims of the primacy of Western scientific knowledge. A sound knowledge alone was however insufficient to engage in the larger political process. The stage for the magnification of public health interests was set according to the Western norms of middle class civil society agitation through interest groups and associations. Conducted usually in the English language, these involved the preparation of public education events, petitions, rallying support from likeminded groups and making representations to government committees.

On the surface, health politics in the colony might have seemed exclusive to the European community and therefore prejudicial to their Asian counterparts, particularly the non-literate working classes. Such would concur with the notions of colonial capitalism, defined generally as the control of capital by the highest level of business and government of an alien power, excluding the larger society from either the capitalist enterprise or meaningful participation in formal politics.[106] But, the barriers of entry were not just restricted to the non-Western organisations as the representatives of the Rockefeller Foundation, the League of Nations and the women based temperance

[105] Similarly, the advent of the print media was recognised by Sivaramakrishnan as a pivotal tool in strengthening and disseminating indigenous medical traditions in colonial Punjab. Sivaramakrishnan. *Old Potions, New Bottle.* pp.104-158.
[106] Syed Hussein Alatas. *The Myth of the Lazy Native* (London: Frank Cass, 1976) p. 2.

groups discovered. Rather than being welcomed for providing additional health work, these organisations were regarded by the colonial civil society with suspicion and hostility. The charges were often framed in the spectre of idealistic but naïve outsiders interfering disastrously with local affairs. The following chapters will demonstrate the strategies adopted by different groups in colonial Malaya to avoid being marginalised. On the whole, the more successful groups were represented either by their key personalities (cultivated from within the ranks of colonial civil society), or/ and external figures with similar agendas.

Among the main ethnic groups, the Chinese community was the most prominently represented in the political mobilisation of health. Aside from the pioneers of developing private medical institutions and charities, there was also an elite core of Anglicised Straits Chinese well schooled with the modus operandi of Western civil society. [107] These bicultural personalities were able to negotiate between both vernacular cultures of the Chinese community and that of their Western counterparts. Governing the colony with a handful of English civil servants supported only modestly by a police force and military garrison, the British became reliant on the social and economic networks of the diaspora Chinese community.[108] Similar efforts were also made by the European women lobbying for social hygiene and maternal health in the colony. These activists and medical volunteers came to British Malaya on their own basis, rather as wives of European colonial administrators or merchants. Unlike the other players engaged as stakeholders of the colonial economy, these women legitimised their positions in the British colony through their appeals of maternal welfare and sexual morality to British public opinion in their social hygiene messages.

Broadly speaking, the male English administrative elites were considered the personifications of colonialism in Malaya. Their interactions with their female, ethnic Chinese and American counterparts could however not be categorised as a straightforward coloniser/colonised relationship as the latter were themselves largely foreign to Malay society. On the contrary, it would be necessary to categorise them as "secondary colonisers", who in their negotiations with the British officials created a

[107] Yen Ching Huang. *A Social History of the Chinese in Singapore and Malaya, 1800-1911* (Singapore: Oxford University Press, 1986).
[108] Yen. *Class Structure and Social Mobility in the Chinese Community in Singapore and Malaya, 1800-1911* (Adelaide : University of Adelaide, Centre for Asian Studies, 1983).

whole new colonial civil society. To Ann Stoler, such reshaping of community contours engenders new relationships of power as it destroys or freezes traditional relationships.[109]

A common strategy of the Malayan health movement was to win the support of the prominent medical and political personalities in the territory. These were mainly, former and current colonial administrators, senior health officers and religious elites (as in the case of the temperance movement seeking support from the Anglican Church in Singapore). To be further explained in the next two chapters, it was the merchant and trade associations who were most successful in forging a network of alliance of colonial administrators and senior medical officials. Groups like the Straits Settlements Association, based in London and comprising prominent former administrators were often quick to jump in solidarity with local business to push for, or oppose public policies deemed detrimental to the freedom of trade. Meanwhile reputable medical officers would be present in meetings of business associations speaking on public health issues on a personal basis, or continuing to endorse commercial agendas long after their retirement.

At the end, the gauge of the successes of these activities would be dependent on the extent in which these health based movements could sway not just policies, but also public opinion towards their agendas. Health lobbies intending to spotlight the disease they felt most pressing would usually begin by painting it as a potentially, if not actually an apocalyptic malice. Aside from magnifying the usually grotesque physical symptoms and the dreadful epidemiological potential, campaigners would also quantify the infectious diseases in economic and demographical tones. The public concerns for this disease would be constructed to be inadequate and in need for heightened attention in the form of increased public expenditure, harsher legislations for non-compliance as well as extensive public education.

Daniel Fox's attempts at theorising the health politics of the modern British and American experience comes in useful in providing the lens of understanding health politics in colonial Malaya. The moves towards centralisation in Britain, of allocation of

[109] Ann Stoler. *Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule* (Berkeley: University of California Press. 2002) p. 22.

prestige, and of aggregating media, political and professional interests made disagreements easier to resolve than in the United States. The American system he thought, was however marked by a more fragmented polity, a fluid class structure, and a narrower range of ideological debate.[110] In short, any conflict within the British system takes place usually within a consensus.[111] As will be elaborated in the subsequent chapters the narrative of civil society and health politics in colonial Malaya would be categorised as "consensus within conflicts." Contrary to Fox's framework, the interest groups had no reservations in openly and harshly critiquing the colonial health service. Nonetheless, underlying such debates was an un-stated consensus triangulating between British colonial governance, the primacy of modern medicine, the core responsibility of the state in public health provisions, as well as the duty of society to monitor its progress.

Ann Stoler argues that colonial cultures were more unique hybrids than direct replicas of European societies. In spite of the selective appeals of European residents to the ideals of civil society, the development of a more plural political culture in Malaya could not be considered as parallel with that of Europe. On the contrary, the "homespun" practices of political articulations by organised citizenry through the platforms of petitions, town hall meetings and letters to the newspapers provided new meanings in specific colonial orders.[112] Like formal dress codes, dinner galas and sumptuary laws, these civic participations not only reiterated a diasporic assertion of European middle class values. Simultaneously, it also concretised the colonials' difference with the colonised in a structure described by Benedict Anderson as a "tropical gothic middle class aristocracy".[113] In systematically and selectively excluding and including what was deemed to be representative of the common good, the colonial civil society had conjured its own unique public discourse. To Michael Warner, the circulation of ideas and activities in the public depends:

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[110] Daniel Fox. *Health Policies, Health Politics: The British and American Experience,1911-1965* (New Jersey, Princeton University Press, 1986) pp. 3-4.
[111] Ibid. pp. 207-8.
[112] Ann Stoler. *Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule.* p. 24.
[113] Benedict Anderson. *Imagined Communities: Reflections on the Origins and Spread of Nationalism* (London: Verso, 1983) p.137.

[...] on an arbitrary social closure (through language, idiolect, genre, medium and address) to contain its infinite extension; it depends on a hierarchy of faculties that allows some activities to count as public or general, while others are thought to be merely personal, private or particular. Some publics, for these reasons, are more likely than others to stand in for the public, to frame their address as the universal discussion of the people. [114]

These "arbitrary closures" of health politics by the colonial society had in turn distinguished it from a public separated largely from the rest of the "publics" in British Malaya. In fact, one could even map out a social geography of these health based movements which were confined to the key centres and economic belts along the cities and plantations of the Western coast of the Malaya Peninsula. Aside from their economic significance, these zones were also the hubs of political governance and literary productions. Hence, the towns of Ipoh in Perak, Kuala Lumpur, the administrative capital of the Federated Malay States, Georgetown in Penang, and most importantly, Singapore, the heart of British colonial authority were more than urban centres of transportation and distribution. It was in these settlements where the headquarters of business and civic associations, government departments, printing houses and newspapers were based. It was also in these centres where the substantial degree of lobbying by health movements originated.

[114] Michael Warner. "Publics and Counterpublics". *Public Culture*, 14.1 (2002) 49-90, p. 84.

Conclusion: "Philanthropic-Missionary" and the "Government-Political."

Alison Bradford traces two broad genealogies of public health, the "philanthropic-missionary" and the "government-political." As the state assumes the roles of the charities and parishes, the responsibility of the latter begins to recede.[115] A huge component of this chapter has been devoted to laying out the expanding role of the colonial medical services into the Malayan Peninsula. The growth and diversification of medical and public health institutions were manifested by the burgeoning volumes of passengers screened at quarantine centres, the utilisation of outpatient services and the propagation of public health education. Another indication of the increasing gaze of the colonial medical authority on society was the increasing corpus of epidemiological data gathered on a host of infectious diseases and socio-cultural patterns of mortality. This information permitted the colonial medical services to prioritise its resources specifically at the various heads of the hydra of diseases. There is a need to be reminded of the haphazard evolution of the seemingly monolithic and progressive institutional memories of the colonial state. As discussed earlier, this development should not overshadow more realistically limited legacies of the colonial medical services. Added to this, its was also limited by the reception of the indigenous and migrant populations. Seen as being chronically overcrowded or mortuaries, government hospitals were often regarded with suspicion.

This chapter has laid out the fluidity of state-society relationships. As Peter Evans stated, "Just as the neoclassical political economy negated the state's role in the development of a more productive and efficient society, society also negated the state's ability to speak to non-market needs."[116] The development of public health services by the colonial state should not be seen merely as a top down approach. In contrast, it was one of filtering of ideas from the middle through countless debates and lobbying in committees, parliament, newspapers, forums and other public meetings. Health lobbies in this regard organised themselves along the basis of specific interests or other economic and communitarian associations to push for their agendas on public health.

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[115] Alison Bradford. Imperial Hygiene: *A Critical History of Colonialism, Nationalism and Public Health* (New York: Palgrave, 2004) p. 7.
[116] Peter Evans. "The Eclipse of the State? Reflections on Stateness in the Era of Globalisation",*World Politics* 50.1 (1997) 62-87, p. 79.

Through the claims of modern medicine, such had involved a complex process of political manoeuvring by players to negotiate with the state, identify enemies and establish wider social networks. It was in these activities that enabled diseases geographies and politics to be articulated and mapped in different dimensions, creating new possibilities for social arrangements. The story of civil society involvement in social medicine will commence in the next chapter on health in urban areas, the first British colonial settlements. Through concerns and debates over medical licences, permits on food and drugs, insanitary streets and congested housing, the question of who calls the tune and pays the piper will begin.

Chapter 2
Belly of Ideals & Opening the Municipal Belly

So it was with the river
We lived with it for years, you see.
Its notorious whiff of decay,
The bankside scum and lighter congestion
The quaint unloading of the boats
A nostalgic reminder of a way of trade
Backwatered by containers and computerisation
When the Prime Minister said: "In ten years time
Let us have fishing in the Singapore River...
A river is a system filled by many streams,
Clean the river meant clean most of the island
When we began the Clean Rivers Campaign
We felt as if the surgeon had cut open the belly
To find the cancer spread through the body.[1]

Poems from *No Other City*

The municipal ideals in Malaya can be summed up in the word "sanitation". The question of public health ought to be the primary consideration of the government and where this is neglect for the pursuit of perhaps more elaborate, but less useful measures the authorities are denying the public the full benefits of their power. If acquiring precautions against the inroads of diseases are taken, lesser things can wait.

Editorial from *The Times of Malaya*. 3 Feb 1916

Introduction: "Municipal Ideals"

In 1977, the Singapore government announced a massive cleanup of the Singapore River, a project that took a decade to complete.[2] In the process, an entire historical legacy as well as an environmental nightmare was unearthed from the riverbed.[3] By the 1980s, not only had the filth and stench been removed from the river basin. At the same time Singapore, internationally reputed for its cleanliness, seems to have realised the

[1] Alvin Pang & Aaron Lee (eds). *No Other City. The Ethos Anthology of Urban Poetry* (Singapore: Ethos: 2000) p. 40.
[2] See: Lee Kuan Yew. *The Singapore Success Story; From Third World to First, 1965-2000* (Singapore: Times Academic Press, 2000) pp. 173-84.
[3] See: Joan Hon. *Tidal Fortunes : A Story of Change :The Singapore River and Kallang Basin* (Singapore: Landmark Books, 1990), and Stephen Dobbs. *The Singapore River; A Social History, 1819-2002* (Singapore University Press, 2003) pp.99-125.

"municipal ideal" envisioned in *The Times of Malaya* in 1916. In contrast to the efforts of the contemporary state, the colonial civil society was more involved in metaphorically "opening the belly" of the port city by persistently spotlighting urban health issues. Aside from law and order, the provision of public health services and the implementation and enforcement of medical regulations were significant debates. These measures, or the apparent lack of them, produced considerable discussions.

This chapter reviews health lobbies within Malaya's urban contexts. Analysis of the colonial city has been predominately framed along the contestations between European administrators and indigenous society, with public health used as an important medium to theorise such tensions. The involvement of the health lobbies in British Malaya however questions the simple binaries between imposing imperial municipal administrators and defiant subjects. Instead, different factions within colonial society used public health issues to magnify social grievances. As will be further elaborated, those opposing the expansion of "Western" sanitary and medical licensing measures included European commercial and legal representatives threatened by what they perceived as arbitrary measures of the state. In addition, as the medical facilities established by ethnic Chinese merchant groups and international health organisations have shown, public health was not the exclusive domain of the municipal authorities.

The discussion of these issues be framed along three areas. The first consist of the tussles arising between sanitary reforms and legal prerogatives and economic interests in the area of urban planning. The second component deals with the licensing of medical practices and drugs within the urban medical market. The last section covers the role of health lobbies in strengthening public health infrastructure of the urban areas. This encompasses their efforts in establishing quarantine centres, hospitals, the medical school, and the League of Nation's Epidemiological Centre in Singapore. While there are several urban centres within British Malaya, the study of urban health will be focused predominately on the port-city of Singapore. Aside from being the seat of the colonial government, the island's densely populated, highly urbanised and socially porous environment generated substantially more public health debates than its counterparts in the peninsula. It was also in the prominent medical institutions within the city that witnessed the participation of community groups and health lobbies in the establishment of prominent medical institutions.

Health politics and re-activating the City Space

Considerable attention has been devoted to the study of spatial contestations between the hegemonic notions of Western urban planning against the landscape of the vernacular bazaar cultures in colonial cities.[4] Examining colonial African cities, Garth Meyers observes:

> The concentration of order in British colonial cities in Africa used architecture, landscape and design features in political ways; shaped space in domestic and neighbourhood environments and gendered those environments to further the cultivation of public opinion on the spot, to make the populace accept [colonial] rule and goodwill as commonsense reality. [5]

To James M. Jacobs, most studies of colonial urbanisation tend to deactivate space by seeing the city as the uncontested imposition of imperial territorial arrangements.[6] On the contrary, Meyers finds colonial governments being simultaneously "weak and strong, centralised and fragmented, with overlapping and ambiguous agendas."[7] British administrators in African colonies struggled in implementing a "coercive system of exploitation", while trying at the same time to gain moral legitimacy.[8] In the case of colonial Singapore, Brenda Yeoh highlights the colonial urban environment as "embodied and expressed the tensions and negotiations, conflicts and compromises between different groups."[9]

Nonetheless, the relationship between medicine and colonial cities has been generally limited to the narratives pertaining to the imposition of, and resistance to, the apparent

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[4]The concept of the "colonial city" was raised by G.J. Telkamp in 1978 who underscored its importance within the broader historical processes of colonialism, capitalism and industrialisation. Robert Ross and J. Telkamp. *Colonial Cities: Essays on Urbanism in a Colonial Context* (Boston: Martinus Nijhoff/Leiden University Press, 1985). For works on colonial urban health, see: John Leavitt. *The Healthiest City: Miwaukee and the Politics of Health Reforms* (New Jersey: Princeton University Press, 1982) and Kalala Ngalamulume. *City Growth, Health Problems and Colonial Government Response: Saint-Louis (Senegal), from Mid-Nineteenth Century to the First World War* (PhD Thesis : Michigan State University, 1996).

[5] Garth Meyers. *Verandahs of Power* (New York: Syracuse University Press. 2003) pp.7-8.

[6] James Jacobs. *Edge of Empire: Postcolonialism and the City* (London & New York: Routledge, 1996) p.21. See also: Mark Elvin and G.William Skinner(eds) *The Chinese City between Two Worlds* (USA: Stanford University Press, 1974).

[7] Meyers. *Verandahs of Power*. P. 10.

[8] Ibid.

[9] Yeoh. *Contesting Space*. p.18.

scientific rationality of Western biomedicine.[10] Anthony King points out the overriding concern of the 19th century metropolitan city, and increasingly that of the colonies, was one of health. The particular ideological and cultural context of British urban planning was the primacy of "health, light and air," a reaction to the sprawl of the industrial city. This to King, was the peaceful path to reform and the strategy of municipal authorities to alleviate what was defined as social pathologies.[11] Externally, the city was thought to be vulnerable to epidemics from migration and trade while its squalor was attributed to the inadequacies of public health infrastructure coupled with haphazard urban planning.[12] As the case of colonial Malaya's health lobbies will indicate, through such discourses, interest groups tried to mould the spatial politics of colonial Singapore.

"Orderly and Scientific method"

David Harvey conceptualises the relationship between the study of urbanisation beyond that of a legal political entity or a physical space. Instead, it concerns a "process of capital circulation; the shifting flow of labour power, commodities and capital; the spatial organisation of production and the transformation of time-space relations."[13] Designated as free trade zones to counteract Dutch monopoly, the early British colonial settlements in Penang and Singapore attracted significant regional and international capital. The opening up of the China market after the Opium Wars further boosted the status of these ports. By that time, Singapore had eclipsed Penang as the major colonial port city in British Malaya. Labour began to follow capital flows as demand for workers for the burgeoning economy skyrocketed. Ethnic Chinese and Indian migrants made use of the new trading networks spurred by the easing of restrictions, flocked to Malaya through the ports of Penang and Singapore.[14] The pivotal positions acquired by these settlements were to McGee, the "nerve centres" of colonial exploitation. Concentrated in these centres were the institutions through which capitalism extended its control over

[10] Teresa Meade. "'Civilising' Rio de Janeiro: The Public Health Campaign and the riot of 1904", *Journal of Social History*. 20(1986):301-22.
[11] Anthony King. *Urbanism, Colonialism and the World Economy: Cultural and spatial Foundations of the World Urban System* (London, New York, Routledge, 1991) pp.53-4.
[12] Kalala J. Ngalamulume. *City Growth, Health Problems, and Colonial Government Response*. pp.336-40.
[13] David Harvy. *The Urban Experience* (Oxford: Blackwell, 1989) p.6.
[14] Mary Turnbull. *A History of Singapore. 1819-1975*. pp. 97-102.

the colonial economy like banks, agency houses, trading companies, shipping companies etc."[15]

To the trading community, the essential locomotion behind these nerve centres was the "invisible hand" of the free market, or the uninhibited exchange or flow of labour and capital. Any interference with this principle, particularly through high taxation or excessive regulations was regarded as a threat to the settlements' fragility. The guarantee of the property rights of the inhabitants was thus of utmost priority to the transitory nature of these cities. Fearing the emergence of anti-capitalist radical ideals spreading to the colonies from Europe at the turn of the 20th century, the *Penang Gazette* warned: "Trade unionism, state socialism the policy of pampering of the working classes, interference with private enterprise and other innumerable evils of government by catchwords are already sapping the foundations of Great Britain and will simply wreck havoc in this country."[16] For the merchant community, even costly and inconvenient public health regulations could be potentially ruinous. Reflecting this sentiment was a petition of prominent ethnic Chinese merchants in GeorgeTown, Penang protesting the implementation of metered water taps to address the wastage of water supplies in the town. Claiming that this regulation of directly charging consumers would deprive the poor who would turn to unhealthy water supplies, the petitioners argued:

> The prosperity of this town is dependent upon its health as well as its trade, and your petitioners have experienced the heavy loss that can be caused to them by a few cases of plague, and submit that a serious outbreak of cholera or plague would undo in a few weeks the work of many years and reduce what is now a flourishing and progressive town into an "infected Port" shunned by ships. [17]

Other than the provision of law and order, the role of the state in establishing a physically healthy environment was also crucial. Within these considerations lay the dilemmas for both the colonial government and civil society on the balance between regulatory prerogatives and liberal economics. In principle, these values were not considered trade offs. Apart from laissez faire economics, the adequate supplies of fresh

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[15] T.G. McGee. *The Southeast Asian City: A Social Geography of the Primate Cities of Southeast Asia* (London: G.Bell, 1967) pp. 56-7.
[16] *P.G.* 3 March 1908.
[17] "Correspondence on the subject of water supply of George Town of Penang". *S.S.L.C.P.* 2 December 1904. pp. C.173-91.

water, healthy labour and living conditions were considered to be essential for the prosperity of the colony.[18] Supporting the 1906 Simpson Report proposal for extensive state public health involvement, the *Penang Gazette* felt the prosperity of a port depended on having a "clean Bill of Health." This should "suffice to silence the critics who object to the far reaching recommendations in the report on grounds of the vast expenditure on public health."[19]

A "clean Bill of Health" lay in the proper ordering of the cityscape and sustained maintenance of a built environment. This spirit was embodied in the despatch from the Undersecretary of the Colonies to the Straits Settlements where:

> It must safely be said that careful planning of this nature, bearing in mind the probable development over a long period, is essential to the fullest and healthiest development of which any particular city is capable. Town and regional planning in the proper sense is not a matter of new projects which would not otherwise have been undertaken; but should rather be regarded as an orderly and scientific method of controlling work already in progress or inevitable in the future in a manner which secures the best and most far reaching economical results from current expenditure as it takes place. Nothing is more expensive than haphazard or narrowly conceived development which will later involve the costly undoing of earlier mistakes.[20]

Among the more poignant emphasis was the application of "scientific method" coupled with fiscal prudence in health related public health works. The framing of urban health was in turn set within such boundaries. The construction of the social aetiology of diseases in Singapore can be summed up in the following observation from the *Malay Mail*:

> We cannot go on indefinitely taking chances with public health. The gamble might one day prove a very disastrous one. Sometimes it seems to be just good luck that permits of the compilation of tolerable and favourable health status[...]A walk round our streets reveal many undesirable features which call for obvious action from a health standpoint[...]Among them may be mentioned processes of malodorous conservancy casts through the heart of the town as late in the morning as 8.30am; dozens of unsightly and insanitary rubbish bins overflowing with nauseous garbage, foodstuff displayed in the markets,

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[18] Makepeace. *One Hundred Years of Singapore*. pp. 315-31.
[19] *P.G.* 29 July 1907.
[20] *S.S.L.C.P.* 1931. "Appendices. Report by President of Municipal Commissioners, G. W. Byrant. Town Planning." p. C403.

contaminating well-high inevitable, and innumerable breeding places for mosquitoes indicative of general covetousness and ignorance.[21]

The editor's comments reflected the outstanding grievances about official inertia of the municipal authorities towards public health. Until the establishment of the Municipal Health Department in 1887, there was no governing body specifically devoted to the public health of the Singapore.[22] As the *Penang Gazette* noted:

So far as we are concerned, we shall be delighted to abandon drains, water supply, plague quarantine, and tuberculosis and turn to high politics and the higher criticism as soon as there is some indication that the proper authorities are moving in the matter and that discussion has given way to practical work...Until then, we proposed to discuss sanitation ad nauseam.[23]

Among the subjects discussed "ad nauseam" were that of housing, medical licences and health institutions.

Municipal: "The Germ of the matter"

Until public housing was introduced in the 1920s, market forces determined accommodation patterns in the Malayan cities.[24] Population pressures were the most acute in the municipal confines of Singapore. Incentives to shift outwards were only apparent after the First World War with the substantial improvement in transportation networks to facilitate the development of military bases.[25] Population pressures were felt most poignantly by the ethnic Chinese immigrant coolie classes. Those who worked in the city found lodging in pitiful makeshift cubicles partitioned from rooms designed for significantly fewer dwellers. In the meantime, the streets and alleys of the colonial port city were also choked with hawkers and vendors to the displeasure of the municipal authorities. Apart from the seemingly unsightly spectacle, the urban conditions of Singapore were also seen as a public health concern. The overcrowded houses were pathologised as diseased environments devoid of light, space and ventilation. As such,

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[21] *M.M.* 10 September 1920.
[22] Makepeace. *One Hundred Years of Singapore.* pp. 321-23.
[23] *P.G.* 29 July 1907.
[24] See Brenda Yeoh and Lily Kong (eds). *Portraits of Places: History, Community and Identity in Singapore* (Singapore: Times Edition, 1995).
[25] Yeoh. *Contesting Space.* pp. 93-101.

bringing breathing space to the city was desired on both humanitarian and sanitary grounds.[26]

The newspapers were in fact one of the proponents of greater sanitary reforms aimed at the urban environment of the municipality. As the *Straits Times* stated in 1887, "The time has been growing fast of late. However speculation and builders may push on the houses, they cannot keep pace with the demand for more rooms. The heavy and fast increase in population results in dangerous overcrowding of the available premises."[27] Promulgating ideas of diseases and ventilation, the paper argued strongly for the need to open up more spaces within these houses which would "act as purifiers or disinfectants of the vitiated and contaminated air which invariable surrounds and hangs about human dwellings. They may each be regarded as small atmospheric oasis, and it is unfortunate that their numbers and locality should be more a matter of circumstance than selection."[28]

The editor however laid blame almost singularly on the Chinese community in the colony where: "[...]some of the most crowded streets and masses of buildings inhabited chiefly by Chinese who delight in building their houses en bloc, and gauge the surrender of every inch of unoccupied grid, Singapore has little allowance of open spaces."[29] Less than a month later, the paper accused the authority of incompetence claiming that the "fearful loss of life is bad government," which had neglected to rectify the "bad habits" of the people and also for poor drainage and water supply. As it recommended:

> The public health should not be sacrificed to the views of any class or clique, no matter how strong may be the vested interests caused and least of all in a large town of Singapore[30][...]The absolute power and right of the government to interpose in all cases where the public interest suffers from Municipal negligence lies open to objectionable opinion may be expected to be always divided on the point whether the limit of government interference for the whole community should be circumscribed or extended.[31]

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[26] See Manderson. *Sickness and the State.* pp. 114-26 and Brenda Yeoh. *Municipal Control, Asian Agency and the Urban Built-Environment in Colonial Singapore, 1880-1929* (PHD Thesis: Oxford University Press, 1991).
[27] *S.T.* 7 June 1887.
[28] *S.T.* 9 January 1889.
[29] Ibid.
[30] *S.T.*. 7 June 1887.
[31] *S.T.* 14 May 1887.

By the 1920s, this belief in preventive public health in the urban settlements had replaced the curative aspects of medical science as seen in a report on tuberculosis in Singapore argued:

The Commissioners are advised that clinics and sanatoria, while they have their value, are of minor importance, and that the only way to deal with the question is to attack it at its roots. This means that slums must be dealt with in such a way as to admit air and sunlight[32][...]The Health department freely uses the powers conferred by Section 229 of the Municipal Ordinance concerning the closing and demolition of insanitary dwellings and Section 243 of the same ordinance concerning buildings obstructive to light and ventilation.[33]

A substantial change in direction came from the recommendations of the Simpson Report in 1907. Commissioned a year earlier by the colonial authorities to undertake a major survey into the sanitary conditions of Singapore, Professor J. Simpson attributed the housing conditions in the colonial port-city to be a range of architectural defects of buildings. The London based King's College professor highlighted mainly the sub-division of floors and rooms into cubicles without provision for each cubicle of windows opening directly to external air, as well as the absence of backlanes and open yards to allow for drainage and air circulation. This, he accused, was a result of overcrowding by the illegal segmentation of private residences into tenement houses.[34] Observing the trends of development of the city, Simpson felt:

It is evident that Singapore, though covering a very extensive area, is suffering, even in the early stage of its development, from two forms of overcrowding. The first is overcrowding of areas with houses, and the second is overcrowding of houses with inhabitants. These two factors are well-known causes of high death-rates and the remedy lies in the removal of these causes in the old localities and in their prevention in the new and in those parts of the old not yet overbuilt on.[35]

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[32] *S.S.A.R,* 1931. No 93. "Report on Tuberculosis by President, Municipal Commissioner, W. Bartley." 12 October 1931. p.C.400.
[33] Ibid.p.C401.
[34] Professor J. Simpson. *Report on the Sanitary Condition of Singapore.* 1907, pp.28-9.
[35] Ibid.

Attempting to rectify these conditions, he proposed a series of measures segregating and zoning different functions within the house and around the streets as part of "fixing a definite relationship" between open and built spaces. [36] Until 1942, the Simpson Report became the template for the public health regulations in the urban built environment in Singapore.

The *Straits Settlements Annual Report* in 1925 highlighted the colonial government's commitments towards urban sanitary reforms: "The question of town improvement in Singapore has been engaging the attention of the government and financial assistance has been promised to the Municipality for the purpose of providing open spaces in bad slum areas of the town. Assistance is also being afforded for the provision of backlanes."[37] In addition, the authorities embarked on financing large schemes for the opening up of suburbs "with the double object of providing additional housing facilities and securing accommodation for persons dis-housed as a consequence of the improvement schedule."[38] Meanwhile, there were also increased and systematic inspections of houses in the city area of Singapore.[39]

Earlier attempts to restrict trading activities at verandahs to free up space for public health reasons were met with non-cooperation from merchants and riots inspired by triads.[40] Hence, what was taken for granted as the sanitary science of cleanliness became a difficult balancing act for the colonial administrators. Explaining this difficulty to the Chamber of Commerce, Governor Frank Swettenham remarked: "If we make the conditions of life too difficult for these people, they would not come near you. I have endeavoured to introduce sanitary measures in place in the Native States if you go too far, the natives will say "no too muchee regulations, not likee".[41]

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[36] Ibid.
[37] *S.S.M.R.* 1925. p.65.
[38] Ibid.
[39] In the Siglap district at the fringe of the Municipal boundaries, officials conducted in 1922 a routine inspection of 10,422 homes and assessed building plans of 101 houses (in which 42 were approved, 52 were amended according to regulations, and seven applications were rejected). Sanitary cards detailing standards of cleanliness were also distributed to the district. *SSAR*,. 1922. p. 68.
[40] See Yeoh. *Contesting Space*. pp. 250-4.
[41] *S.S.L.C.P.* 1902. Appendices. "Correspondences: Governor Swettenham to W.C Brown (Penang, Chamber of Commerce)". 31 Oct 1902. p.B210.

Rumblings also arose on the proposals of the government to cut back lanes across houses to improve lighting and ventilation. With stakes as property owners and ratepayers, a strong element within the community was aghast at being blamed for poor public health and with it, the prospects of being not just poorly compensated, but having to face financial penalties as well. These dissatisfactions were in turn articulated through the members of the Legislative Council.

An early opponent to the amendment to Section 153 (a) of the Municipal Act, where owners of land putting up buildings shall leave a "five foot way" in front of the building for public benefit was G.S. Murray. He claimed this law would deprive the owner of twenty five percent of the land he acquired for the building purpose. If the purpose was the general good instead of private gain, this financial burden he felt should be bored by the whole community in the form of taxes. As he concluded in his speech, "the individual owners of land should for the benefit for the whole town, and without recovery compensation, have to give up certain of their rights, by leaving open spaces at the back of their houses, I think to be grossly unfair."[42] Murray's stance was backed by another assemblyman, J. Burkinshaw who felt "The air spaces are desirable, we are all probably agreed, but as to who should pay for them, we are not agreed."[43] As Dr James Galloway warned on the need for an equitable system of compensation to retain investment confidence, "The position of Bombay is entirely different, having a well assured future being the outlet of a large hinterland. The future of Singapore and Penang on the other hand are not assured. They depend on transit trade and that will only be kept as long as these ports are of a real advantage and not an incubus[...]"[44]

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[42] *S.S.L.C.P.* "Municipal Bill". 9 July 1896. p. B162.

[43] Ibid.

[44] Ibid. "Municipal Bill" 13 December 1902. p.B.182. Dr James Galloway was a prominent private practitioner in Singapore during the 1880s. In 1897, he started the "British Dispensary." Aside from his medical practice, Galloway was actively involved in the colonial civil society through his participation in the various committees. Makepeace. *One Hundred Years of Singapore. Vol.1.*p.502.

Joining the British non-official members were their ethnic Chinese counterparts. This came from the argument made by Dr. Lim Boon Keng where:

"I do not think the provision in this clause will attain the object, and the result will be that houses will be smaller and the spaces left about the buildings will not help in the free circulation of air. If the government wishes to help the municipality to put down overcrowding, it is not by the diminution of the size of the individual houses that it will be done, but by the prohibition of buildings in a crowded state. I do not think it is fair that the landowners, after they have bought a certain piece of land from the government, should be told when they proceed to build in that land, that certain parts of it have to become free spaces for the benefit of municipality. [45]

The opinions of the representatives were nevertheless not unanimous. Disagreeing with the other speakers Mr Sheldford thought that the issues of property rights and compensation were diverting Singapore from the real threats of diseases of overcrowding. Citing the case of the recent outbreak of bubonic plague in Hong Kong, he strongly stated: "There is no doubt that a great deal of the want of sanitation here is in consequence of houses being back to back, with no space for free ventilation and admission of air."[46] Refusing to back down on the opposition, the Colonial Secretary responded it was the obligations for builders to make such space from the very beginning, and would therefore not be entitled to any claim of compensation from the state.[47]

Not satisfied with the rebuttal, the various interested bodies continued their protests. The matter was raised more than a decade later in the Legislative Council by Mr. E.C. Ellis linking the issue of compensation with that of the principles of the free market. As he stated: "This is really the bacillus of the whole misunderstanding, the origin of all the intricate points of compensation we have to deal with. The germ of the matter that people are not paid for their property[...]To give people security of property attracts traders. Nothing drives traders away like taking that security away."[48]

In attempt to show the enormity of the situation in Singapore, the Colonial Secretary "doubted if there is any other part of the world where the housing question is so

[45] *S.S.L.C.P.*"Municipal Bill". 9 July 1896. p. B164.
[46] Ibid. p. B162.
[47] Ibid. p. B164-5.
[48] Ibid.

disgraceful as in Singapore and death rate so enormous", to which Mr Ellis replied: "The awful slums of London are famous throughout the world from the horrible conditions and yet it has the lowest death rates of any city in the world." Nonetheless, the Colonial Secretary insisted it was the duty of the owners to make adjustments for such requirements without prompting or compensation by the government.[49]

Earlier in 1909, Ellis raised the issue of the back lanes in the Council. While acknowledging the government ought to have the authority to make these back alleys, he reasoned, "when you run a lane through a row of existing buildings, something different ought to be paid for compensation than what the amendment propose[...]he ought to be compensated not only for the value of actual number of square feet, but depreciation caused to the reminder of the home[...]"[50] In spite of the appeals, the Governor replied:

> No plant, no animal and certainly no human being can live in a place for which air and light are, absolutely excluded...We see no reason whatsoever for giving extra compensation...What hope is there of this place becoming self sufficient in the matter of labour if it were not that we are able to draw upon India and China for our supply, we should have closed down on an early date. We cannot expect these people to come in if they continue to die at the present rate.[51]

The Governor's stance seemed to ignore the possible hardship the measures could have on the residents of these houses, most of whom were tenants rather property owners. Highlighting this was another Chinese non-official Seah Liang Seah in the Legislative Council:

> Professor Simpson's back-lane system caused difficulty regarding houses because one family who formerly occupied one house now had to separate into two houses. Formerly, in a house they had two rooms, a front room and a back room, with an air-well and a passage between, but since the back-lane system has been introduced, the Municipality will only allow one room[...]Now except for a kitchen at the back it is all front part and open space. [There is] no air well[...]That is hard on the people who occupy many of the houses. Formerly, a family of husband and wife and two children could occupy the front part, and say a mother-in-law and sister-in-law the back, and downstairs the coolie could be

[49] *S.S.L.C.P.* Municipal Bill". 24 Jan 1913. p.B22.
[50] Ibid. 3 September 1909. p.B118.
[51] Ibid. p.B119.

accommodated. Now there is only one room for the family, and the mother-in-law and sister-in-law must find another house. [52]

In spite of the insistence of the colonial authorities, the recommendations of the Simpson Report only became partially implemented. Aside from the magnitude of the change, the government was met with significant opposition, from the inhabitants, amplified by civil society representatives.[53] In sum, the limitations highlighted here reveals another dimension of the tensions between state and civil society over the interpretation of the free market principals in relationship to property rights, health of labour.

Markets and Medical Markets

Another area of contestation was the debate over the legitimacy of medical practitioners. Generally, the colonial medical infrastructure was constantly outstripped by a burgeoning urban population, the majority unfamiliar with Western clinical sciences. Instead, they were served by a host of private dispensaries, herbalists, and medico-religious healers. Struggling to provide medical services, the authorities had not paid significant attention to the regulation of the medical market to the dissatisfaction of several circles.[54] The first rumblings were expressed in the editorial of the *Straits Times* on 22 October 1859 on concerns of alleged quackery from non-European medicine. Highlighting on the "maze of perplexity" of the medical systems of the various ethnic groups, the paper scoffed at the general absence of distinction in anatomy. Proposing that death be certified only by qualified English practitioners, the editor appealed to the government who in his opinion "is the only office who can organise measures whereby these obstructions to our attainment of [medical] knowledge might be done away with."[55]

[52] Ibid. "Housing Difficulties Report." 1918. Vol. 2.p.135.
[53] Yeoh. *Contesting Space*. p. 168.
[54] Manderson. *Sickness and the State*. pp. 18-26.
[55] *S.T.* 22 October 1859.

A similar call was made in the Legislative Council by Dr Robert Little in protest against the official permit for the Tamil community in Singapore to stage a religious procession to appease the gods during a cholera epidemic in 1873. In his view:

They were no ordinary processions. Persons went about with knives and swords, crying out and howling and screaming, some of them almost naked, fighting with fancied deities or spirits, and others resting on points and nails wishing to do something to allay their fear of these gods. Most of the individuals in the Tamil processions were under the excitement of either bhangs or spirits. Instead of allaying fear, they added to it and were the cause of spreading cholera instead of preventing it. [Dr Little] considers an established law of all civilised places that no men ought to be allowed to terrify or annoy others.[56]

The more concerted push came by the late 1890s by the Malayan Branch of the British Medical Association as well as the Coroner's Office. Since the establishment of British administration in the Straits Settlements, recruitment of trained doctors to the colonial medical services had been difficult due to unfavourable remuneration and working conditions. Gradually, the core of British doctors in the colonial medical services and in private practice was broadened. However, many of these practitioners felt a need for professional recognition. They found non-European methods inscrutable and potentially dangerous, and were also concerned with competition from medical practitioners of different European nationalities. Keen on adopting a more protectionist policy, several British doctors called for a tit for tat measure, where if they were not allowed to practice in other European countries or colonies, the same should apply for non-British practitioners in Singapore.[57] Summing up the concerns of the medical community in the First Reading of the Poison's Act, the Attorney General stated:

There have been many representations by the medical men and others that a measure of this kind would be exceedingly useful that it is wanted both for the protection of the public and also to a certain extent from the interests of qualified medical practitioners. There can be no doubt that in a place like this where we have a long time without stringent regulations, an unfortunate condition of things will arise. There can be no doubt there is a considerable amount of quackery prevalent, some of it perfectly innocent, some of

[56]Dr Little was actively involved in the development of the medical services in colonial Singapore, having opened a seamen hospital in 1851 served as Singapore's first Coroner in 1848 and as Surgeon to the Singapore Volunteer Rifles a decade later. He was also the pioneering batch of un-official representatives when the Legislative Council was established in 1867. He retired in 1882 and passed away in Blackheath in 1888. Makepeace. *One Hundred Years of Singapore*. p. 501.

[57] Not all European medical practitioners were against indigenous or "native" medicine, as seen in the calls for Dr C.W. Daniels not to dismiss these traditions which were useful for curing dysentery and other intestinal diseases. "A plea for the Scientific Study of Native Drugs and Poisons". *The Journal of the Malayan Branch of the British Medical Association* 1904-5. pp. 3-5.

it harmful and civilised peoples have generally adopted a law something of this kind to combat the evils that have arisen.[58]

In 1903, the Government commissioned a study comprising two community leaders, Tan Jiak Kim and W.L. Napier and the Attorney General A.R Colleyer into the non-European medical market. This study came in light of the plans to introduce legislation concerning the licensing of poisons and medical practices. Firmly supported by the Chinese Advisory Council, the Commission acknowledged the cultural differences of Asian medical practitioners, herbalists and medical halls from what it understood as conventional Western standards. Added to this, the European members of the Commission were also impressed with professional standards of consultations and prescriptions in these medical halls. The most important consideration however, was the infrequency of these traditional medical practitioners in administering potentially poisonous substances for internal use. Tan wrote:

He was in favour of a check being placed on the sale of poisons and he would vote for the Bill but he hoped he had made himself clear that in the case of Chinese dispensaries, they would be exempted from this ordinance. He was sure that on enquiry it would be found that they seldom gave poisons. They seldom used them at all, and then only in conjunction with other medicines for external application. He did not ask for the withdrawal of the Bill, but he did ask that if it became law, the Governor would exempt Chinese chemists and druggists.[59]

Significant debate however took place when the Bill went through its first reading on the degree of exemption from the legislation. Concerns were raised on the urgency in outlawing all seemingly unorthodox remedies which had implications on the consistency of the law with regards to the primacy of modern medicine. Among the proponents for greater stringency was Dr W.C. Brown, a medical practitioner and an unofficial member in the Council who felt:

It has been considered with some reason that any move in the direction of registration and restriction might create such a difficulty. But the evil has now become too great, too urgent, and there should be no delay in dealing with it by a Bill for the registration of chemists and those who deal in European drugs.

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[58] *S.S.L.C.P.* 1 December 1904. "Medical Registration Bill". p. B27.
[59] *S.S.L.C.P.* Ibid. 4 November 1904. "The Poisons Bill". p. B161. See also: *S.S.L.C.P.* "Report on the Poisons Bill", 3 March 1905. p. C32.

Many of the drugs which these bogus chemists sell are the latest, the least understood, the most potent and most deadly. Extraordinary recklessness and ignorance characterised their operations..."[60]

A more complex argument was made by Mr. W.J Napier. His main contention was the extent to which the legislation concurred with the spirit of free market economics and, also the universality of Western biomedicine[61]. Regarding the former, he thought it fair only to allow practitioners to continue their trades as long as they have not contravened the liberties of their clients or have subjected them to any dangers. In appealing to the sentiments of industry and enterprise responsible for the prosperity of colonial Singapore, Napier reminded the Council, "There are a certain number of gentlemen practising medicine without qualifications here, men who have the confidence of their patients and have had a certain amount of training and have embarked their lives and capital in their business here."[62]

Nonetheless, the solicitor's regard for vernacular medicine was not entirely favourable. Napier found the protectionist stance of the Malayan Branch of the British Medical Association inconsistent in the light of its compromised stance to tolerate the existence of "native" medical systems:

I understand the Malaya Branch of the British Medical Association want to go further and to say that all persons who do not follow the native systems of therapeutics according to ancient Indian, Chinese, or other Asiatic method" or who are not registered according to this Bill shall not be allowed to practice here. In other words, although they would admit the Malay Bomoh or any other person who has not studied Western methods of medicine to practise here, yet if any man has attained some knowledge of European medicine[...]they would not allow him to practise, even although he is able to give a lesser fee than the ordinary medical practitioner.[63]

Napier also asked the government to clarify its stance on non-British Western trained doctors either in serving in ships calling in the ports in British Malaya as well as qualified Asian doctors trained in Western medical sciences in India and China. What would be the implications on the standards of Western medical profession if traditional trades, considered inferior were permitted and modern medicine rejected just because of

[60] *S.S.L.C.P.* 6 April 1903. "Morphine Ordinance Amendment Bill". p.B30.
[61] Napier arrived as a lawyer in Singapore 1889 before his appointment as Attorney General in from 1907-09. Makepeace. *One Hundred Years in Singapore* p. 231.
[62] *S.S.L.C.P.* 10 March 1905. "Medical Registration Bill." p. B27
[63] Ibid.

the issues of nationality? Probably aware of these differences before the Bill was introduced, the colonial administration attempted to balance the conflicting priorities presented by the community representatives. Explaining the rationale of the policy, the Attorney General attempted to neatly divide the categories between Eastern and Western medicine.

> Nothing contained in this ordinance shall be construed to prohibit or prevent the practice of native systems of therapeutics according to ancient Indian, Chinese or other Asiatic methods. It will be recognised that there are careful men as a rule. If you go to their shops, you will see the care with which their drugs are kept apart and their prescriptions mixed. There is also the great point that they do not as a rule use strong medicines as in the British pharmacopoeia and therefore there is very much less chance of an accident or serious injury if some mistakes does happen with drugs that are not so strong. A considerable number of people, I believed depend upon these medical practitioners for medical advise and to forbid the use of their systems and drugs would seem a hardship. This section will prevent any vexatious interference with oriental herbalists who may be doing good to their fellow men. It must be observed that it does not extent to the relief of such persons as pretentious to treat people under European methods of pharmacy.[64]

In effect, the legislation became a product of an awkward political compromise of the state to the demands of competing factions within civil society. Rather than being resolved, the controversies continued to be resurfaced. Criticising the government for its alleged indecisiveness towards indigenous and regional medical practices, the *Penang Gazette* warned: "Not only do the native system of therapeutics according to Indian, Chinese and other Asiatic method kill a great many more patients than they ever cure: but particularly nullifying the previous useful legislation designed for purpose of suppressing quackery.[65] The local medical culture was also in the meantime unexpectedly defended by Europeans with the same convictions of Napier. During the second reading to the amendment of a Bill pertaining to the Sale of Food and Drugs, an official member, Mr. A.Agnew raised Clause Five of the law which stated: "proprietors of old and well established patent medicine will be compelled to specify and disclose the formulas of their medicine if they do not do so, they will be precluded from marketing their medicine in the colony." Calling it a "distinct injustice", he predicted the amendments would mean:

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[64] Ibid.
[65] *P.G.* 14 May 1907.

It would be a distinct hardship to many people in the colony if the old and well established patent medicine were taken off the market. Throughout the colony, there are many outlying districts where medical attention is difficult to procure and in most cases in these districts, well known patent medicine are kept by various inhabitants. People have faith in certain patent medicine and in many cases have good reasons for having this faith. If through legislation, the properties of these medicines were to withdraw their articles from the market, it seems to me that the public would suffer to a very grave extent. [66]

Apart from his appreciation and respect for the secrecy of formulas in the vernacular market, the assemblyman's arguments were also premised on the rights to commercial privacy where legal pressure of disclosure contravened the principles of the free market. Agnew's suggestions were accepted by the Attorney General after consultations with the Principal Medical Officer and the Chambers of Commerce.[67]

The debates over the licensing of medical and pharmaceutical practices exposed a more muddled dilemma of interest groups with regards to the regulation of the medical market. The colonial authorities were compelled into balancing between implementing a regulatory body based on Western biomedical principles against acknowledging the reliance of indigenous healing cultures. Added to this were pressures to protect British practitioners against competition from their European counterparts in the colonial port city. On the pretext of the high professional standards, the minimal use of controlled drugs and their services to the migrant populations, these non-Western medical centres were given legal recognition to operate in colonial Singapore. In effect, such debates can be considered to be crucial in determining the public space and legitimacy of different players within the medical market in Singapore.

"God helps those who help themselves"

By attempting to mould public health policies, health lobbies in colonial Singapore were at the same time contributing to the municipal public health infrastructure. These efforts stemmed from a combination of frustrations with the inadequacies of the colonial medical services and the desire of community groups for wider public recognition. In addition, Singapore's strategic position in Southeast Asia had also attracted international health organisations wanting to establish their presence in the region.

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[66] *S.S.L.C.P.* 30 December 1918. "Sale of Food and Drugs". p. B176.
[67] Ibid.

Among one of the first commentaries the *Straits Times* published were the relationship between poverty, diseases and the health services. Highlighting police figures of 6,000 starving and a hundred dying a year from hunger and diseases, the paper lamented: "It is now more than twenty five years since the first formation of the settlement at Singapore [in 1819], but still up to this hour, no provision is made for the poor, no asylum is provided for the sick, no refuge exists for the destitute."[68] While it took the initiative to establish a benevolent fund for the sick and dying in the colonial city, the *Straits Times* also called for more generous and sustained public involvement:

> Were government to provide for destitute and wretched beings stalking through our streets, a step our humane and worthy governor would no doubt but most cheerfully perform, new taxes must necessarily be levied or rate of assessments be augmented in order to meet the demand. Were government to undertake this task, it must likely be on a scale at least liberal, and commensurate with the demand that exist for perjuring aid, but at the same time, a government established is not likely to be so economically convicted as a voluntary organisation whose officers must feel a pleasure in discharging the duties of humanity that belongs to such an institution.[69]

In the meantime, the colonial civil society based largely in Singapore was preparing to make its own public provisions. In a public meeting on 3 February 1844, a total of seven resolutions were passed calling basically for the establishment of a pauper hospital. Among the more actively involved were E.J. Gilman, Tan Kim Seng, C.Spottiswoode, T.O. Crane, W. Napier, Syed Omar Adjunied, M.F. Davidson, C.A. Dyce , J. Gutherie, W.R. George, T.Smith and W.H Read Three philanthropists had already came forward with support, with Tan Tock Seng providing $5,000 Straits Dollars, Chong Long, $2000 and Syed Omar Adjunied donating the site for the hospital.[70]

After extended correspondences supported by the Governor, the Bengal administration approved the petition. Established in 1844, the Tan Tock Seng hospital signified both the public initiative of the merchant community, and also the shortcomings of the Indian

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[68] *S.T.* 11 September 1845.
[69] *S.T.* 30 September 1845.
[70] Charles B. Buckley. *Anecdotal of Old Times Singapore. Vol. 2* (Singapore: Fraser & Neave, 1902) p.408.

administration, which the Straits Settlements came under. As Donald and Joanna Moore observed:

> The building of the Tan Tock Seng hospital was one of the earliest manifestations in Singapore of the profound Chinese conviction that God helps those who help themselves. If Government would not provide what they wanted, they would provide it for themselves. The history of the Chinese in Singapore and in what is now Malaysia is littered with examples of this principle at work. And almost always one of the merchant classes was in the forefront of each development-giving funds, eliciting funds and crystalising opinion. [71]

Subsequently appropriated by the government, the hospital was administrated along Western models of medical science. This institution however, represented a more collective multi-racial effort of the colonial civil society.[72] On their own, the Chinese merchant community in both Singapore and Mainland Malaya had also established their own medical charities organised along Chinese medicinal practices. The most prominent was the Thong Chai Medical Hall, established in 1867, engaged Chinese physicians to provide free consultations and prescriptions to the labouring Chinese classes. This was followed by two other institutions in the urban parts of Singapore like the Sian Chay Ee Siah in 1901 and the Kwong Wai Shui hospital in 1910.[73] These medical charities and community hospitals were a major provision of public health services duirng the early decades of colonial Singapore. In the "public health" section of the annual reports of the Straits Settlements for much of the mid ninetieth century, they were the "anti-mendacity" societies catering to the poor and sick in the towns.

Another major initiative from the Chinese business community came in the promotion of medical education. The concept of a medical school was first suggested by the colonial medical services, and a Commission was appointed to enquire about this possibility. It concluded: "Great advantage which could accrue to the Colony and the Native States by the introduction of a system of training which would produce, out of local material, men better qualified to supply the demand for Assistant Surgeons and

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[71] Donald and Joanna Moore. *The First 150 Years in Singapore*. p.250
[72] Buckley. *Anecdotal of Old Times Singapore. Vol. 2.* pp.408-16.
[73] Yeoh. *Contesting Space*. 112-8

General Practitioners among the native population and the poorer inhabitants."[74] Despite the advantages, the colonial government stated it could not afford to undertake this project. Undeterred, the local community led by Mr Tan Jiak Kim petitioned to reconsider the proposal on both medical and economic grounds. Tan argued the importance of the medical school in the cultivating local practitioners who would be able to mediate between Western biomedical science and Asian traditions:

> A large portion of the native population are unable and unwilling either on the grounds of expense or of ignorant prejudice to avail themselves of the service of European practitioners and are accordingly thrown back upon persons with little or no medical training with results very far from satisfactory[...]The importance of a general comprehension of proper sanitary conditions and habits is of paramount importance to any country and your petitioners feel that no measure can so successfully diffuse this understanding as the provision of a proper supply of trained medical men who are in racial sympathy with those whom they attend.[75]

In response, the Acting Colonial Secretary provided a financial list for the petitioners to meet for such an institution, covering buildings and equipment, staff and maintenance expenses and scholarships, amounting of $71,000 Straits Dollars.[76] If this amount could be raised, the Governor "would be prepared to invite the Legislative Council of the Colony to provide for the payment of the necessary staff and maintenance charges estimated provisionally at $13,200 per annum and also to provide ten scholarships for ten students annually."[77] The terms were agreed upon on 21 February 1905. Underscoring the importance of the colonial civil society, especially the support from the ethnic Chinese community, the Governor expressed officially "unless we can rely upon that cooperation, it would be of very little use our attempting to start such an institution. We have not only got to a very great extent, to overcome what I may call Eastern prejudice against Western methods, but we have also got to secure that the best material available shall be forthcoming to the students."[78] Using the high mortality rates

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[74] *S.S.L.C.P.* 1905. Appendices. "Correspondence regarding the Establishment of a Medical School in Singapore: Petition from Certain inhabitants of Singapore to Governor Sir John Anderson." 8 September 1904. pp. C37-41..

[75] Ibid.

[76] While the Colonial Secretary claimed the government would be able to cover the building expenses having saved $1,000 from the closure of a female leprosy ward, it faced with problems in other areas. This included the cost of equipment, estimated to be $10,000, and $60,000 for the provision of scholarships to attract local students. *S.S.L.C.P.* 1905. "Acting Colonial Secretary, Straits Settlements to Tan Jiak Kim". 4 October 1904. pp.C.41.

[77] Ibid.

[78] Ibid. 14 April 1905. "Vote for medical School" p. B83.

to press his case further, the Governor stressed: "when we find that out of 10,000 deaths in the colony, over 6,000 are uncertified, I think if further proof were needed that we required further medical assistance, it is there."[79]

Being the first Western-based academy of higher learning in British Malaya, the King Edward VII Medical College was paramount in developing and localising the position of modern medicine in the colony. Established in 1905 in Singapore, the college was not only instrumental in training a non-European core of medical practitioners to fill the ranks. Becoming the seed of tertiary education in Malaya, the medical college fostered a new generation of local elite drawn from the increasingly professional class instead of the traditional merchant community.

Community and commercial interests together with international health organisations were strongly visible in influencing the development of port health infrastructure. Expressed through the media, the initial complains were lengthy procedures vessels and passengers were subjected. Accusing the government of "clothing a dwarf with a giant's armour" in a free trading "Eastern colony in accordance to English ideas", the *Straits Times* felt:

> It probably never occurred to the [government] to think how all their elaborate and minute regulations, upon which they have appeared and expanded so much pains would be viewed by the outside public-by merchants and traders who make this place for what it is-how they will affect a large and important branch of the trade of the place[...]It probably would occur to them to think they were moving all their ingenuity to cut not only their own throats, but the throats of other people.

Responding to the restrictions imposed by the port authorities during a cholera epidemic, the paper claimed that such "seriously prejudices commerce" and:

> It is the duty of the government to assist the merchants of the settlement by making their trade as unrestricted and cheap as possible. It is pretty clear that cholera is an epidemic and as a danger to the other places. does not exist. and the official announcement of that highly gratifying fact should not be needlessly postponed.[80]

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[79] Ibid.
[80] *S.T.* 4 September 1895.

It was also the media who brought to public attention the supposedly gross inefficiency of the port health services. While the *Straits Times* agreed in principle for the need for quarantine defences, it was distressed by the slow rate of clearance at the ports. It quoted a case of vessels directed from Port Swettenham due to a malaria epidemic in the area, to St John's Island. Already suffering a loss of an hour by this diversion, the ships, which had arrived at 10.30 in the morning, were only inspected two hours later. This was considerably shorter compared to another case where ships arriving in Singapore at dawn were only inspected three hours later. In this respect, the *Straits Times* concluded: "no one will cavil the government for taking most rigid precautions for preventing the spread of plague, but existing regulations[...]are calculated to irritate and annoy and cause financial loss."[81]

Apart from lobbying for more effective quarantine services, colonial civil society undertook to make supplementary provisions. Until the 1920s, port health and quarantine facilities were not monopolised by the state. Before the establishment of the Far Eastern Epidemiological Intelligence Bureau, information on infectious diseases around the world was relayed through the local press along with shipping news. This had a significant impact in mapping the disease landscape for the merchant community reliant on the smooth flow of goods and labour around the region. There were also attempts by the ethnic Chinese merchant community to set up their own quarantine centres, having been frustrated with the colonial health services.

This effort was however not appreciated by the government or the English language papers which seriously doubted the effectiveness of Chinese medical practices. This disapproval was seen in an angry debate between the ethnic Chinese representatives and the editor of the *Penang Gazette*. Explaining the background of the situation was a Kaw Cheng Sian who traced the origins of the plan to the rise of smallpox and plague in Penang. With only one Apothecary tending to 65 suspected infected patients in the government quarantine camp, the Chinese community leaders proposed opening two quarantine camps at Batu Gantong and Dato Kramat. An agreement was made to release a few thousand dollars in the charity funds to convert a huge house into a quarantine

[81] Ibid. 6 June 1901.

camp staffed by Western and Chinese medical practitioners. Altogether, a total of $77,000 Straits Dollars was spent to administer the quarantine centres.

In the spirit of public charity, Kaw stated "Chinese of the Straits Settlements have hitherto assisted the government or municipality in many ways and are ready to offer the assistance in matters of public importance."[82] Nonetheless, the quarantine centres were shortlived as the authorities were disinclined to place the administration of port health services in Asian hands. As commented by the *Penang Gazette*:

> We are pleased to see that the Municipal commissioners are taking the question of the Chinese quarantine camp seriously, and they are not inclined to let it be run on Chinese lines with no qualified medical supervisor. We have every consideration for our Chinese fellow colonist, but at the same time, we think that they ought to be given to understand that in sanitary questions they should conform to European ideas instead of placing difficulties[...]We believed that Straits Chinese are far ahead of their compatriots resident in China in all ways and we think that they should try to set an example of enlightenment by paying more attention to sanitary matters and offering less puerile opposition to all reforms. Besides, they ought to remember that Straits Settlements was not specially created for them.[83]

The concrete involvement in the port health of the colonial port-city by non-government bodies became realised by the League of Nations. Prior to 1925, the colonial health services in British Malaya had to rely on the Paris based Office International d' Hygiene for epidemiological information. The inconveniences were summed up in the excerpt of the *Straits Settlements Annual Medical Report* as early as 1905:

> A port health officer in the East suffers from the want of a proper intelligence department. The International Office of Public Health in Paris might be in the moon as far as he is concerned, for news reports are incomplete, are not classified into weekly periods, are months in arrears when received, and are only issued in French. For us the world is an oblong figure lying between the longitude 30° E and 150° E and between 30°N and 30° latitudes. At the four corners of the figure are the ports of Port Said, Durban, Sydney and Kobe. These are generally speaking the gates of access to us from the outside world. Within the above Eastern area all the ports of commerce are of vital significance to us. There are about twenty six major ports and twenty six secondary ports. We need an Eastern Public Health Bureau in some central place such as Singapore. The Bureau would receive and disseminate telegraphic and written

[82] *P.G.* 4 March 1904.
[83] Ibid. 2 March 1902.

reports of infectious diseases, would keep health officers posted in current sanitary legislation and would arrange for periodical health conferences for the exchange of ideas. [84]

The momentum for pushing for the establishment of the Bureau was gained only after the First World War with the concerns for the spread of infectious diseases caused by the demographic disruptions from the conflict. A platform for resolving such concerns was established by the Health Organisations of the League of Nations. In 1923, the former Straits Settlements Medical Officer, Norman White was despatched by the League to survey the port health facilities in the Asian continent. In his report, White called for a regional bureau to monitor epidemiological information more effectively.[85] The need for an epidemiological intelligence service in Asia was again highlighted in the fifth Congress of the Far Eastern Association of Tropical Medicine, held in Singapore in September 1923.[86]

With little opposition, the representatives from the Health Organisation approved one of the League's first major public health projects to be located in Singapore with the cost of setting the institution being partially sponsored by the Rockefeller Foundation.[87] Regarded as a crucial asset, the station was well received by the colonial medical services where:

The Bureau has proved of great use throughout all Eastern Arena-to Singapore no less than all the other places and returns have been received from an increasing number of ports, rendering the information more and more valuable as time goes on. In addition to these returns, a large amount of information with regards to infected ships was received through the Bureau. By this means, the various governments are saved the experience of telegraphing to all the neighbouring governments, which have received regular information by the Bureau.[88]

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[84] *S.S.M.R.* 1905. p. 71.
[85] Norman White. *The Prevalence of Epidemic Disease and Port Health Organisations and Procedures in the Far East.* Report presented to the Health Committee of the League of Nations. Geneva, 1923.
[86] *S.S.M.R.* 1925. p. 13.
[87] The Rockefeller Foundation committed a sum of $50.000 for the first year in addition of a total of $125,000 for a five year period. Manderson. "Wireless wars in the eastern arena: Epidemiological surveillance, disease prevention and the work of the Eastern Bureau of the League of Nations Health Organisation, 1925-42". Weindling (ed). *International Health Organisations and Movements, 1918-1939.* p.113. Weindling (ed). *International Health Organisations and Movements, 1918-1939.* p.113.
[88] *SSAMR*, 1925. pp. 13-14.

From 1925 to the eve of the Japanese invasion, the Epidemiological Centre operated as an important element of urban health, not just within Singapore, but around the region as well.[89]

Conclusion: Health lobbies and the Colonial City

As this chapter has shown, the medical discourses in the urban context were intricately entangled with more fundamental interests and anxieties. The principles of the market crouched in terms of labour and capital mobility, or free trade and individual property rights, were regarded as paramount. While a "clean bill of health" was in principle synonymous with a healthy economy, the actual implementation of what would be western notions of public health policies generated significantly discord. Through their representatives, property owners strongly opposed the sanitary measures to reduce overcrowding in houses. With back lanes and air wells arbitrarily defined with either inadequate or no compensation for the appropriated property, the merchant representatives felt such public health measures to be a greater threat than disease to the free market ideals of Singapore.

Another dilemma between the two priorities came in the regulation of the medical market. While lobbying for a more stringent licensing regime, community representatives were divided over the legitimacy of both Western and indigenous medical practices. On the one hand, English medical practitioners were keen to protect their interests over that of both its European counterparts and folk practices. On the other hand, community and merchant interest groups argued for a more inclusive policy for the medical market to cater to a larger non-European population. This included legal recognition of Chinese medical halls and protecting the patents of vernacular herbalists. Health lobbies in colonial Singapore were also keen to participate in the expansion of the medical infrastructure of the municipality. Community groups and newspapers were active in lobbying for the improvement in the standards of the colonial medical services. More importantly, it was the non-government bodies that were involved in spearheading

[89] See Manderson. "Wireless wars in the eastern arena: Epidemiological surveillance, disease prevention and the work of the Eastern Bureau of the League of Nations Health Organisation, 1925-42", Weindling (ed). *International Health Organisations and Movements, 1918-1939*. p.120-23. For detailed reports of the Bureau see: League of Nations, Health Organisations, *Annual Report*, 1925-1940 (Copies available in the Wellcome Library and the League of Nations archives in Geneva).

the crucial development of public health services within the urban context like the establishment of the Tan Tock Seng Hospital and the League of Nations Far Eastern Epidemiological Station.

Rather than the merely a top-down imposition from the colonial state, it has been shown that the expansion of the colonial medical services as well as the promotion of modern medical culture was negotiated and augmented by colonial civil society. Furthermore, as in the case of colonial Singapore, the efforts of Chinese community groups in establishing of Western medical institutions and their European counterparts' defence of indigenous medical practices calls for a review in the assumptions of colonial medical historiography. Urban health in colonial Malaya was about exposing diseases in dark corners, dangerous drugs and inadequate medical provisions. The next two chapters will revolve around the efforts of plantation associations and the Rockefeller Foundation in depriving mosquitoes and hookworms festered in the soils and drains in the hinterlands of British Malaya.

Chapter 3
Lasting Gardens in the Golden Chersonese: Planters, Estate Health & Malaria

In this [the Malaya Pavilion] area in Wembley Hill, displayed are the resources of the richest, if perhaps the least known of British dependencies. The name of Singapore is at present too much before the eye of the reading public. In connection with plans for a great British naval base in the orient, but the names of the Malayan states of which Singapore is the administrative focus, and where it derives its wealth and commercial importance, are still largely unfamiliar to English ears except when they had mispronounced from the lips of shareholders in rubber companies. It will be the main aim of the Malayan section of the exhibition to remove this prevailing ignorance of what was known to ancient and medieval Europe as the "Golden Chersonese" and to familarise the Englishman not only with the names, but with the history , products and the future possibilities of British Malaya.

The Rubbers' Growers Association on "Malaya at the British Empire Exhibition, 1922[1]

"[...]Everybody knows that the miner takes out of the country the capital that is in it; he takes it out, sent it away, and leaves absolutely nothing in its place; and it appears to me that the planter does exactly the reverse. He comes to the place, and there is nothing in it of any value because we can count the jungle as valueless; and he plants there his capital in something which is a permanent cultivation which will remain in a place. That appears to me almost the highest form of settlement that we can expect, that people should come into a country and turn the jungles into gardens, and gardens that will last."

Address by Frank Swettenham, Resident General, Federated Malay States to the United Planters' Association, 1897.[2]

Introduction: "The Highest Form of Settlement"

Beginning with traveller tales, the imagination of Malaya was vigorously promoted to the British public by the Inter-War decades. The products as well as the arts and crafts were elaborately displayed in the annual British Empire Exhibition and other trade shows, attesting to the contributions of the Colony to Pax-Britannia. A large proportion of this undertaking was predominantly the efforts of joint-stock rubber companies under the umbrella of the Rubber Growers Association (RGA). This commitment was the result of the exponential growth of the rubber industry in the late 19th century with British Malaya as a major player in commercial agriculture.

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[1] *Rubber's Grower's Association Bulletin*. March 1922, p. 412. The term Golden Chersonese was also popularised in Western fiction about the exotic East in the travel writings of Isabella Bird. *The Golden Chersonese and the way thither* (New York: Putman & Sons, 1883).

[2] Taken from: D.J.M. Tate. *The RGA History of the Plantation Industry in the Malay Peninsula* (Kuala Lumpur: Oxford University Press, 1996) p. 180

From small market gardens, the investments in rubber resulted in the massive expansion of plantations. This accelerated penetration of the Malay rural heartlands and primary rainforests had even displaced the subsistence economy of rice crops.[3] Spearheading this expansion were the armies of mainly Tamil immigrant labourers, and as such, their health became crucial to the colony's commercial agriculture.

This chapter elaborates on the participation of plantations as health lobbies in the area of estate health, a subject largely secondary to the reiterated narratives of commercial agriculture or labour. Represented by the plantation companies and their managers, colonial civil society pioneered the development of estate health infrastructure. A significant point of contention was the fundamental differences expressed on the notions of individual responsibility and private property against collective and state obligations. This was articulated through debates on the organisation of preventive health works as well as the responsibilities for the provision of medical facilities.

The negotiations between state and colonial civil society as well as the moulding of biomedical practices through estate health will be discussed in three areas. The first concerns with contentions over the responsibilities of the development and ownership of medical facilities and public health works. This ranged from the transport and quarantine of labourers, custodianship of estate hospitals, regulations pertaining to the living and working conditions of coolies to that of anti-malaria drainage works. In the midst of these debates, the planting community had also generated its own literature and discourses on the management of estate health. Lastly, it was in their experiences with estate health in which the study of malaria was generously supported by planters.

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[3] E. J. Butler. *Report on the Agricultural Department, Federated Malay States*, No.9, 29 April 1919. *Proceedings of Federated Malay States Federal Council*, 1919. p. C75.

"With almost catastrophic suddenness...": Reviewing writings on plantations

In his exploration of the sociological characteristics of commercial agriculture, Edgar Thompson differentiated the plantation from subsistence farms where:

> The plantation is one form in which agriculture is organised for production. It differs from the manor in that production is specialised rather than diversified and self-sufficing. It tends to differ from the family farm in the scale of its operation and in the impersonality of human relations[...]Again plantations may be said to be instituted at points along the community's frontier, sometimes with almost catastrophic suddenness.[4]

Commercial agriculture has however closely intertwined with both the advent of modernity as well as the expansion of European colonial expansion, with large scale cultivations in the colonised territories through slave labour, conscripted, indentured or migrant workers.[5] Organised and supervised by a hierarchy of European and local contractors and managers, plantation labour was organised along regimented, racialised and paternalistic structures of control.[6] The life of the plantation worker in turn, was often told as one of misery. Separated either involuntarily by slave raids or compelled by poverty in their homelands, these coolies were subjected to harsh working and living conditions in the estates, resulting in significant deaths.[7] Responding to financial burdens of the wasteful loss of lives, plantations embarked on a series of public health measures on their workforce. Like factories and mines, the "medicalisation" of estate health by the 19th century became regarded as the appropriation of medical science to

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[4] Edgar Thompson. "Mines and Plantations and the Movement of Peoples", *The American Journal of Sociology*, Vol.37:4(January 1932):603-11. p. 609.

[5] Paul Baak. *Plantation Production and Political Power: Plantation Development in Southwest India in a Long Term Historical Perspective, 1743-1963* (Delhi: Oxford University Press, 1997), Roderick MacDonald. *The Economy and Material Cultural of Slaves: Goods and Chattels on the Sugar Plantations of Jamaica and Louisiana.* (Baton Rouge, London: Louisiana State University Press, 1993). Joseph Reidy. *From Slavery to Agrarian Capitalism in the Cotton Plantation South: South Georgia, 1800-1880* (Chapel Hill: University of North Carolina Press, 1992), Ronald Rote. *A Taste of Bitterness: The Political Economy of Tea Plantations in Sri Lanka* (Amsterdam: Free University Press, 1986), Lucile Brockway. "Science and Colonial Expansion: The Role of the British Royal Botanic Gardens", *American Ethnologist* Vol.6. No. 3. 449-65. p.459.

[6] Kavita Philip. *Civilising Natures: Race, Resources and Modernity in Colonial South India.* pp. 203-37, Ann Stoler. *Capitalism and Confrontation in Sumatra's Plantation's Belt, 1870-1979* (New Haven, London: Yale University Press, 1985), Edgar Thompson. *Plantation Societies, Race Relations and the South: The Regimentation of Populations: Selected Papers of Edgar T. Thompson* (Durham, N.C.: Duke University Press, 1975).

[7] See: E. Valentine Daniel, Henry Bernstein and Tom Brass (eds). *Plantations, Proletarians and Peasants in Colonial Asia* (London: Frank Cass, 1992). Hugh Tinker. *A New System of Slavery: The Export of Indian Labour Overseas, 1830-1920* (London: Oxford University Press, 1974).

the requirements for industry.[8] Observed to be adapted from the developments in the medical discourses, this comprised of compulsory vaccinations, inspections of quarters, health and dental examinations of workers.[9]

In the case of the Malayan Peninsula, the story of plantations is part of mainstream historiography.[10] The commercial cultivation of cash-crops like rubber, pineapple and palm oil is cast as one of "progress" from the pre-modern subsistence economy.[11] As such, a substantial interest has also been devoted to the examination of the development of the plantation industry in colonial Malaya.[12] Nonetheless, these works have tended to foreground the narratives of modernisation and development. On the other end of the spectrum was the emphasis on the voices of the plantation coolies. The rubber boom had put Malaya as a dependency of Western capitalism where to Daniel Headrick, "it was turned into a frontier area, a radically different society from such ancient and densely populated lands as India and Java[...]fast becoming a land of monoculture plantations owned by European firms and worked by Chinese and Indians to provide tires for American automobiles."[13] In this respect, these plantations have systematically exploited estate workers for such purposes.[14] In his critique of the claims of estate health as the vehicle for the improvement of labour health in the plantations, Norman Parmer argues that this thinking has been founded on the implicit assumption of the benevolence of British rule in Malaya. But, this is valid only "if it is understood that

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[8] See: Randall Packard. "The Invention of the 'Tropical Worker': Medical Research and the Quest for Central African Labour on the South African Gold Mines, 1903-36", *The Journal of African History,* Vol.34. No.2 (1993): 271-92, and Vincente Navarro, *Medicine under Capitalism* (New York: Neale Watson, 1976).

[9] See: David Aickin. *From Plantation Medicine to Public Health: The State and Medicine in British Guiana, 1838-1914* (PhD Thesis: University College London. 2001).

[10] Wong Lin Ken. "The Economic History of Malaysia. A Bibliographic Essay", *The Journal of Economic History*, .25:2. (June, 1964):244-62. pp. 253-55.

[11] Singapore also celebrated the centenary of the introduction of rubber in 1877. See: *Singapore Rubber Centenary Committee, 1977.*

[12] See: John Drabble. *Malayan Rubber: The Inter-War Years* (London: Macmillian, 1991), *Rubber in Malaya 1876-1922: The Genesis of an Industry* (New York: Oxford University Press, 1973) Voon Pin Keong. *The European Plantation Rubber Industry in Southeast Asia* (PhD Thesis: University of Hull, 1974).

[13] Daniel Headrick. *The Tentacles of Progress: Technology Transfer in the Age of Imperialism, 1850-1940* (New York, Oxford: Oxford University Press: 1988) pp.245-6.

[14] As observed by Manderson, many estates were reportedly cramped, lacking portable water, latrines and rubbish disposal. Workers were also suffering from poor nutrition which complicated existing infections and lowering resistance levels. Manderson. *Sickness and the State.* pp. 130-137. See also: Ralph Shlomowitz and Lance Brennan. "Mortality and Indian Labour in Malaya", *The Indian Economic and Social History Review*, 29.1 (1992):57-75, and, Ravindra Jain. *South Indians on the Plantation Frontier in Malaya* (New Haven: Yale University Press, 1970).

British rule first made the incidence of disease and death very much worse than before" where:

The clearing of land for estates, the expansion of mining and the construction of public works disturbed the existing ecological balances, causing diseases to spread and multiply. The large immigrant labour forces assembled for these capital investments lacked immune systems. The colonial government, the chief provider of medical services, also lacked experience and knowledge and as a consequence many tens of thousands of workers died.[15]

Manderson attributed the bulk of the poor state of estate health in British Malaya to the half-hearted efforts by an overstretched colonial machinery to enforce the volumes of health regulations on recalcitrant planters who had little regard for their workers:

Plantation managers often ignored regulations and recommendations of authorities such as the Protector of Chinese and the state health officers that were designed to reduce sickness and provide for the care of sick workers. Owners and managers were reported to be absolutely indifferent to the welfare of their labourers, indentured or otherwise[16][....]Diseases carries an economic cost. For this reason, employers shared with colonial medical and health officers concern about the health risks on estates. But they were conservative and reluctant to invest in sanitation or to employ dressers to meet the most immediate needs of those injured or sick, insisting that the government was responsible for environmental control.[17]

The failure of these efforts was reflected in the strikes and demonstrations that swept across the peninsula by the mid 1930s. Either spontaneous outbreaks or orchestrated by emerging radical elements, the labour unrests represented challenges to individual plantation manager as well as the hegemony of colonial modernity or market economics.[18]

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[15] Norman Parmer. "Estate Workers' in the Federated Malay States in the 1920s", in Peter Rimmer and Lisa Allen (eds). *The Underside of Malaysian History: Pullers, Prostitutes, Plantation Workers* (Singapore: Singapore University Press, 1989) p. 179.
[16] Ibid. p.139.
[17] Manderson. *Sickness and the State*. p. 137.
[18] Tai Yuen. *Labour Unrest in Colonial Malaya, 1931-41: The Rise of the Worker's Movement* (Kuala Lumpur : Institute of Postgraduate Studies and Research. University of Malaya, 2000). P. Ramasamy. *Plantation Labour, Unions, Capital and the State in Peninsula Malaysia* (Kuala Lumpur: Oxford University Press, 1994). Charles Gamba. *The National Union of Plantation Workers : the History of the Plantation Workers of Malaya 1946-1958* (Singapore: Donald Moore, 1962).

However well articulated, both the mainstream and revisionist interpretations tend to swing towards either valorisation or demonisation of commercial agriculture. Even with their specific economic interests, the legacy of the plantation managers and owners should be viewed as another element of the colonial civil society in British Malaya. Like the merchants of the municipalities of Penang and Singapore, their interests in estate health were broader manifestations of the tensions between society involvement and state responsibility, private property against public duties.

Background: Ending a "Century of False Hopes"

While the establishment of the British presence coincided with the growing investment in commercial agriculture, the returns were initially modest compared to the tapping of the China trade in the urban colonial port cities. Returns from experiments with the large-scale cultivation of a host of crops like indigo, gambier, sugar and coffee were not promising,[19] and this era was labelled as "A Century of False Hopes" with "long years of frustrations" and "short-lived bouts of profit."[20] The fortunes of the territory changed with the introduction of rubber by the late 19th century, where the Malayan soil was found to be conducive for the Amazonian rubber trees.[21] By the turn of the 20th century, the share of rubber in the export market of British Malaya rapidly expanded to cater to the exponential increase in demand for the rubber based products. From just a single ton in 1907, the production of natural rubber in the Malayan Peninsula skyrocketed to 137 a decade later, reaching a high of 508 by 1941.[22]

Capitalising on the industry were the British joint-stock companies which financed the development of large scale rubber estates. In 1898, there were only 800 hectares set aside for the cultivation of rubber trees. Within a decade, it rose to 103,200 hectares,

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[19] See: Tate. *The RGA History of the Plantation Industry in the Malay Peninsula.* pp.9-178.
[20] Ibid. p. 9.
[21] Rubber seedlings were first sent from the Royal Botanic Gardens at Kew to its counterpart in Singapore as well as the private compounds of a British Resident Hugh Low at Kuala Kangsar in 1877. From these nurseries, more rubber seeds were subsequently distributed to planters in the region. Some planters took to rubber by the late 1890s to supplement the fall in coffee prices, but the harvest in Malaya was modest, where only 345 acres of land was under rubber. Lennox Mills. *British Rule in Eastern Asia* (Oxford University Press, 1942). pp. 184-5.
[22] Colin Barlow. *The Natural Rubber Industry: Its Development, Technology and Economy in Malaysia* (Kuala Lumpur: Oxford University Press, 1978) p.34.

and 906,500 hectares by 1921.[23] By the eve of the First World War, British owned and managed large rubber estates overshadowed the more numerous Chinese and Indian competitors.[24] Unlike the previous generation of planter-owners, most large European owned estates were supervised by salaried managers.[25]

Although the planters were generally scattered in rubber estates along the Western coast of the Malayan peninsula, they were quick to establish their own associations along district and state levels. It was also only through the representations from the various associations that the planter's welfare, labour and estate health issues were concretely discussed. The predominantly European based plantation associations had also forged close ties with the local colonial civil society in the cities as well as being occasionally backed by their parent companies in London. The Malayan English language newspapers, Legislators, former planters and ex-colonial officials were generally supportive of the interests of the planters.

The genealogy of the plantation associations in British Malaya could be traced to the 1890s. However, the impetus towards more coherent institutionalised trade associations corresponded with the rubber boom and the shifts towards the cultivation of rubber. Among prominent associations during the early 20th century were the Malayan based Planters Association of Malaya (PAM) and the London Centred RGA. The former, formed around 1906, consisted of mostly single planter proprietors while the latter was regarded as the front of the joint-stock companies.[26]

For the planting community in Malaya, the supply of labour was a crucial issue for a labour intensive industry in a volatile market. As emphasised by the PAM committee on labour in 1920:

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[23] Ibid. p.26.

[24] In terms of areas of cultivated rubber, both Asian and European commanded a relatively equal share of the land mass, particularly after 1916 when the figures were about 316,500 hectares of European owned plantations compared to 262,200 by Chinese and Indians counterparts. This was significant given the virtual absence of Asian players a decade ago. Ibid.

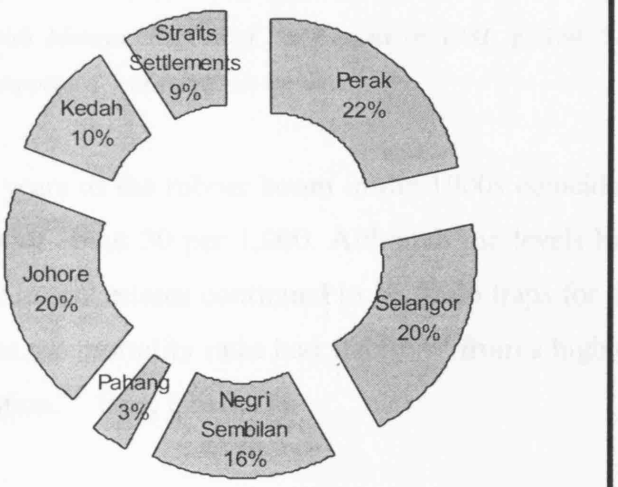
[25] Tate. *The RGA History of the Plantation Industry in Malaya.* pp. 248-71. See also: Richard Stillson. "The Financing of Malaya Rubber, 1905-23", *The Economic History Review,* 24:4 (November 1971): 589-598.

[26] Tate. *The RGA History of the Plantation Industry in Colonial Malaya.* pp.260-1.

In development, Malaya is yet but young. Our industries, although large, are few in number. Others will arise as time goes on; the demand for labourers will increase year by year; and it should hardly be necessary again to point out that unless most strenuous efforts are made by all having a stake in the country to increase the supply of labour, not only will our present staple industries be jeopardised and the prosperity of the country totally impaired; but the natural expansion of which the country is capable will be retarded, to the detriment of Malaya itself, and to the Empire of which we form an integral part.[27]

By the beginning of the 1930s, there were about half a million workers employed in about 1,400 plantations in British Malaya (see Table 15 of Appendix 2 of Annex A and Charts 9 and 10 below for the distribution of the labour force).

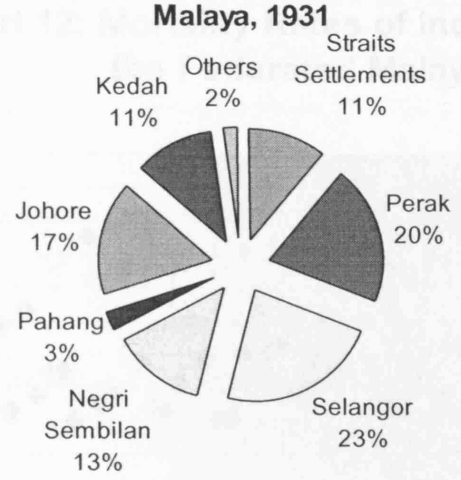
Chart 9: Distribution of Estates in Malaya,1931



Source: *British Malaya. Report of the Census of 1931.* p. 159. See Table 15 of Appendix 1 of Annex A for details.

[27] Planters Association of Malaya. *Report of the Executive of the General Labour Committee, British Malaya, on Indian Labour and Labourers, 1920.* p.13.

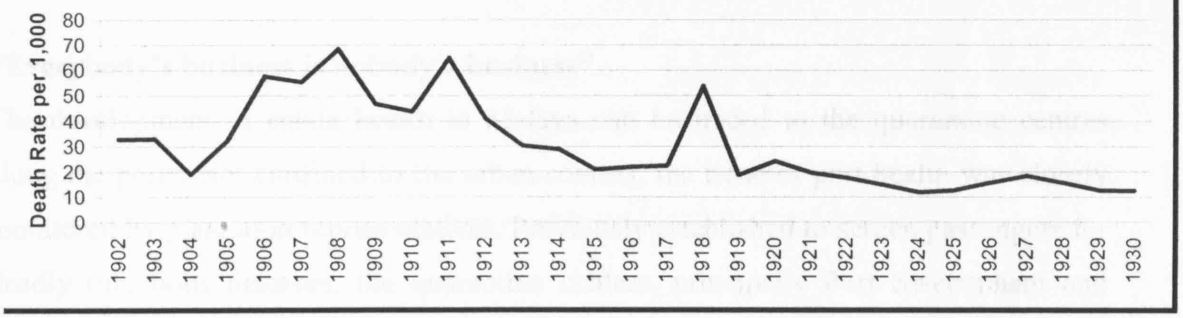
Chart 10: Distribution of Estate Population in Malaya, 1931



Source: *British Malaya. Report of the Census of 1931.* p. 159. See Table 15 of Appendix 1 of Annex A for details.

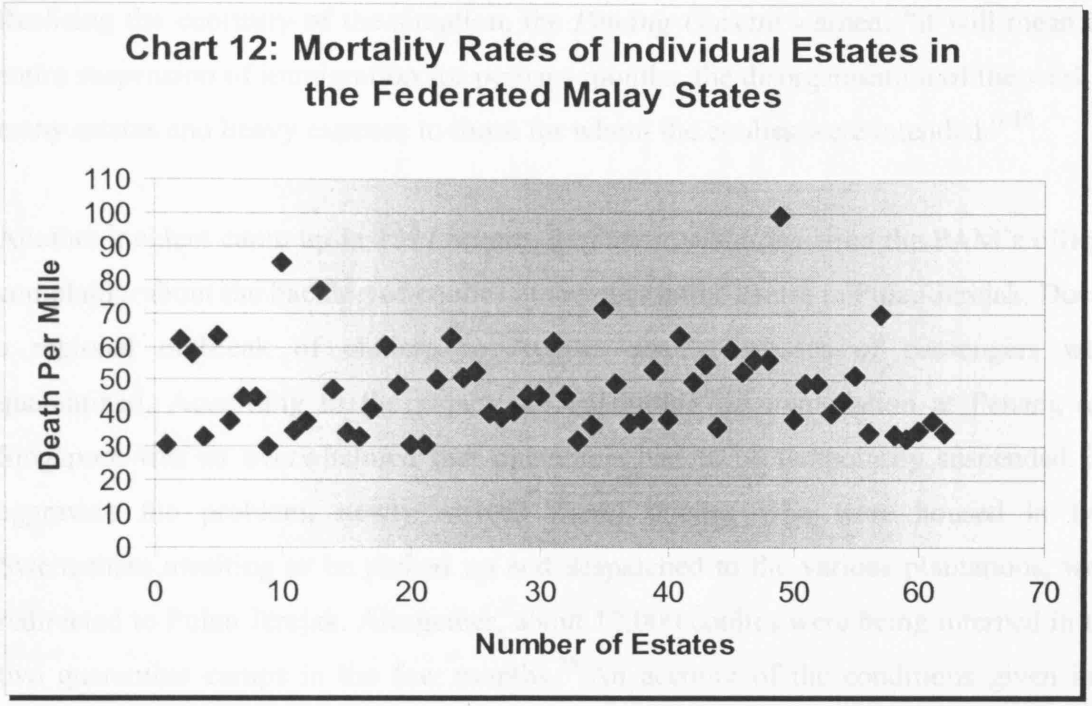
The early years of the rubber boom in the 1900s coincided with the extraordinary high death rates of about 30 per 1,000. Although the levels became to be lowered between 1910-1930, many estates continued to be death traps for their workers. By the 1920s, it seemed that the mortality rates had stabilised from a high of 50 to about 20 per 1,000 of the population.[28] (see: Chart 11).

Chart 11: Mortality of Indian Estate Labour in the Federated Malay States



Source: Complied by Shlomowitz and Brennan. "Mortality and Indian Labour in Malaya, 1877-1933, in *The Indian Economic and Social History Review*, 29,1 (1992) p.71See Table 16 in Appendix 2 of Annex A for details.

[28] This could probably be attributed to the series of rubber slumps especially during the Great Depression between 1929 to 1932 where rubber production, and therefore work was significantly curtailed.



Source: PRO/CO717/59/11. Submissions by Hugh Clifford on estates employing more than 100 people with death rates above 30 per mille, 3 January 1928. See Table 17 of Appendix 1 in Annex A for details.

As seen in Chart 12 above, most estates registered an average mortality rate of their workers of 45 Deaths per mille even if some had gone beyond the 70th mark. Given the cost incurred by such figures, it was inevitable that planters wanted a bigger say in facilitating a smooth supply of healthy labourers. In parallel with these concerns was that of the health of the labourers, ranging from the transportation and accommodation arrangements to working and living conditions.

"Everybody's business is nobody's business"

The development of estate health in Malaya can be traced to the quarantine centres along the ports. Not confined to the urban context, the issue of port health was closely monitored by plantation representatives. Previously established to screen passengers for deadly infectious diseases, the quarantine centres, principally Port Swettenham and Pulau Jerejak, catered to migrant workers heading to the estates. Often hampered by delays, the quarantine procedures were considered by the planters to be responsible for choking both the mobility of labour and further aggravating the workers' health. An early sign of the strain in the quarantine facilities came in 1906 where immigration had

to be stopped because the centre could no longer accommodate any more newcomers. Realising the enormity of the situation, the *Penang Gazette* warned: "it will mean the entire suspension of immigration for perhaps months, the disorganisation of the work of many estates and heavy expense to those for whom the coolies were intended." [29]

Another incident came up in 1911 where the *Times of Malaya* aired the PAM's official complaints about the backlog of coolies at the quarantine centre in Pulau Jerejak. Due to a regional outbreak of cholera in August, greater masses of passengers were quarantined. According to the paper, the quarantine accommodation at Penang and Singapore was so overwhelmed that operations had to be temporarily suspended. To aggravate the problem, newly arrived Tamil coolies who were housed in Port Swettenham awaiting to be picked up and despatched to the various plantations, were redirected to Pulau Jerejak. Altogether, about 12,000 coolies were being interned in the two quarantine camps in the few months.[30] An account of the conditions given in a PAM meeting stated:

> The ground was a black moss of filth and flies; no one could approach within yards of a latrine. The scavenging completely broke down. Smallpox, cholera and malaria were rampant, and the death rates of two camps was 29.6 percent of cases treated...In my seventeen years of experience in the Federated Malay States, I have never known a more wretched collection of coolies than those discharged from the quarantine station[...]Many only crawled away from Penang to die on plantations.[31]

The views of the planters were taken with serious regard by the government as seen in a letter from the Chief Secretary to the Colonial Office dated 23 November 1911 (read to the Committee Members of the PAM meeting) which stated:

> I have the honour to inform you that plans are being prepared for a quarantine station to supplement the accommodation at Palau Jerejak which has been found to be quite inadequate. It is suggested the site should be at Port Swettenham. but before coming to a final decision on the subject, I should like to ascertain on the views of the planting community, which are directly interested in this matter.[32]

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[29] *P.G.* 14 September 1973.
[30] Ibid.
[31] Ibid.
[32] *P.G.* 11 Jan 1912.

A small committee of the PAM was subsequently formed to provide feedback to the Public Works Department on the construction of the quarantine centre.[33] Within a few years, the quarantine centre at Port Swettenham earned the praise of the planters for its efficiency in clearing suspected diseased coolies.[34]

Nonetheless, the PAM continued to keep an eye on port and maritime health facilities. It was keen to demonstrate the responsibility of the poor health of estate workers lay more in the government who was receiving emaciated workers from impoverished parts of India via congested ships before being delayed in overcrowded ports. This was documented in the report of the PAM Labour Committee:

[...]Our visit was not expected[...]The first thing that struck us was the apparent overcrowding of the coolies[...]In the fair season (November to May) the full complement of coolies was permitted by the Board of Trade is 3,150. In the monsoon season (June to October) it is 2,450[...]the deck superficial area is less than 4.2. square feet per coolly in the fair season. In the foul season, when coolies usually come over in greater numbers, the superficial area per coolly is 5.4 square feet[...]The sanitation was very bad. There were only 23 latrines, 15 for men, 8 for women[...]Unfortunately the latrines appeared to be no more popular on the high seas than on the estates and night-soil was generously disposed all over the ship[...]the condition of the latrines was indescribable[...]the manner in which the food is prepared and served on these ships is not all that it might be[...]hospital accommodation on board the ship we visited consisted of one cabin with four bunks in it[...]There was no place for the coolies to bathe. We were told that a short time ago a ship had 3,200 coolies on board apart from other passengers and crew and that the total life boat accommodation was for 150 passengers.[35]

The planters were keen to lobby for the removal of an apparently cumbersome quarantine process devoted to more screening of uncommon infectious diseases instead of addressing the basic health conditions of passengers. While this was not acceded, the government was nevertheless pressured to improve and expand on its port health facilities.[36] In effect, this subject demonstrated to the planting community the merits

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[33] Ibid.

[34] The depot in the station had a capacity of 2,500 residents with proper housing and sanitation facilities as well as decently cooked food and fresh drinking water. *P.G.* 22 Jan 1914.

[35] Planters Aassociation of Malaya. "Memorandum on Preventive Quarantine." *Papers on Tamil Immigration Presented at 12th Annual Meeting of PAM.*, 30 April 1919, section 1, pp.11-13. See also. Parmer. *Colonial Labour Policy and Administration,* pp.59-60.

[36] The frustrations of delays encountered by the arrivals were persisted right into the late 1930s. Observing the conditions of the quarantine stations, a deputation from India reported: "nearly every process [of health examination] was delayed." *V.S. Srinivasa Sastri. Report on the conditions of Labour in Malaya, 1937.* p. 15.

of collective lobbying in shaping public policy. Urging for more spirited involvement, the *Penang Gazette* lamented the lack of unity among planters, "whereby everybody's business is nobody's business. If planters were united, if planting interests were fully represented...the question would be resolved."[37] While considerable friction resulted between planters and the authorities over the quarantine centre, it was the more emotionally charged debates on regulation of public health in the estates that took centrestage.[38]

Estate Hospitals and Health Boards: "Left to Sink and Swim"

One of the first issues discussed by the newly formed PAM was that of estate hospitals. Even before the Rubber boom, plantations were already providing hospital facilities for their workers since the 1870s.[39] In a series of regulations on the Indian Immigration Enactment of 1904, estate health became factored into the general protective legislation for workers in the expanding rubber plantations. Estates were legally obliged to provide for the basic welfare and medical facilities for their labourers, especially in areas without government hospitals.[40] Almost overnight, the plantations were slapped with new requirements which the managers were unable to carry out. Reflecting on the situation, the *Times of Malaya* saw the Labour Code of 1912 as one between the

> [...]Devil and the deep blue sea." If laws were are not passed, immigration from India would be prohibited and the consequences would be disastrous[...]If they make quite certain of not giving the Indian authorities a leg to stand upon in matter of making complaints, the latter would rage at them furiously for sacrificing the interest of the industry and molly-coddling coolie[...][41]

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[37] *P.G.* 14 September 1907.

[38] There were other secondary issues pertaining to estate health like toddy consumption and general nutrition, which surfaced intermittently in the meetings of the various plantation associations, commissioned reports, and in the newspapers. While concerns were raised about the effects of drunkenness and malnutrition on labour productivity, these issues did not take centrestage of estate health. V.S. Srinivasa Sastri. *Report on the conditions of Labour in Malaya, 1937.* p.11 See also: Manderson. *Sickness and the State.* pp. 141-2.

[39] *S.S.A.R.* 1884, p. 211.

[40] Siti Norismah Mohammed Darus. *Health of the South Indian Labourers on Rubber Plantations in British Malaya, 1895-1941* (National University of Singapore: Honours Thesis, 1991) pp.30-31.

[41] *T. M.*. 7 September 1912.

Deputations were made by the United Planters Association to the authorities, but no positive results emerged.[42] On the contrary, the government hardened its stance in the Estate Labourers Ordinance in 1911. This was however strongly opposed by Dr Galloway. Voicing his sympathy for the planters, he argued in the Legislative Council:

> Passing now to the question of hospital treatment, I find that the employer is liable to supply hospital treatment to anyone of his employees who may "require medical treatment." This to me, smacks of pure philanthropy, which, I may mention, does not always go with the earnings of dividends. I do not propose to suggest any alteration at present, but I think it is inevitable, as the experience of the working of this Ordinance accumulates, that a differentiation in the causation of the illness will lead to a differentiation in the amount of the liability of the employer.[43]

Reflecting on the government's attitude toward estate health about a decade later, the *Malay Mail* commented: "planters with no experience in hospital administration, no staff, no hospital buildings [in] estates suffering from outbreak of diseases that followed opening of land in tropical countries[...]were left to sink and swim".[44] The attempts to compel plantations to bear the full burden of estate health were further challenged by the planters themselves. In an Extraordinary General Meeting of the Malaccan Planters' Association, Mr.W.M. Sime asked: "Why should not all employers of labour, construction, bricklayers etc similarly contribute? Why discern between planting industry and other occupations, when it was admitted that estate health was at least as good as any?"[45]

Despite these protests, several of the larger estates began setting up their own hospitals. In the early 1900s, most estate hospitals were makeshift establishments staffed by dressers trained in rudimentary medical care. Subsequently, informal arrangements were made by estates in an attempt to economise on resources. The better-equipped estate hospitals took in patients from smaller estates who were unable to provide medical institutions, and several estates employed private medical practitioners to make

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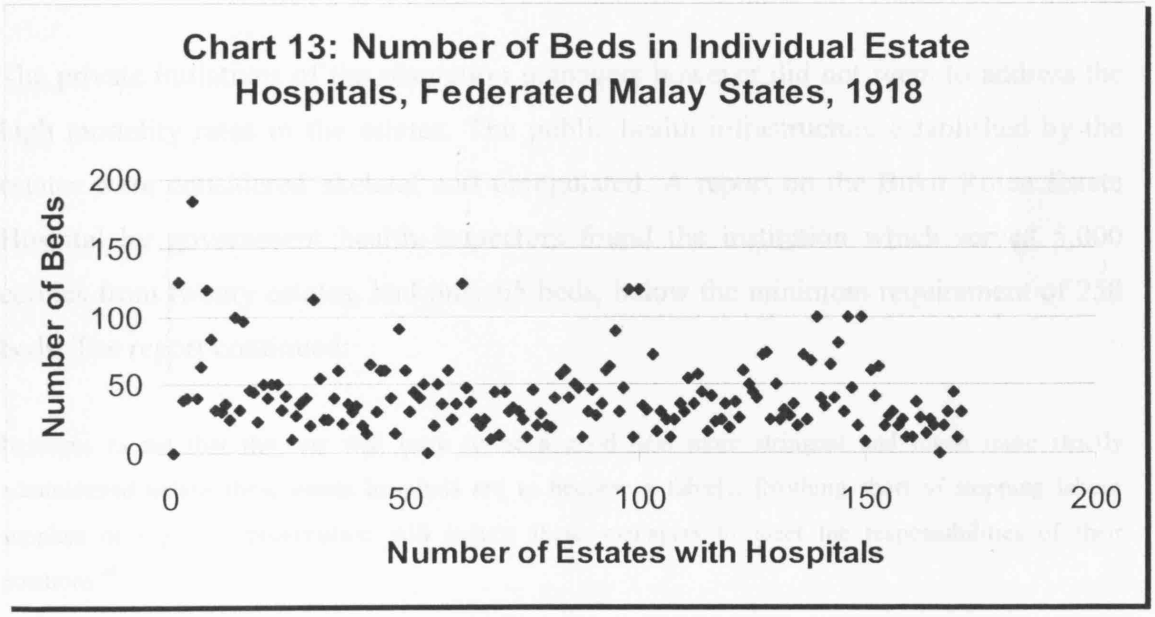
[42] *M.M.* 2 May 1907.
[43] Dr Galloway had also urged the government to reconsider the heavy fines to be imposed on planters flouting the public health regulations. Such would, in his views be difficult for the Chinese owned estates with different ideas of sanitation. *S.S.L.C.P.* "Estate Labourers (Protection of Health Bill)". 3 May 1911. p. B.47.
[44] *M. M.* 7 February 1918.
[45] *T.M.* 7 February 1913.

periodical inspections on their workers. Although there were hiccups in its workings, the arrangements were favoured and encouraged by the colonial administration:

> At the commencement of the year, there were 93 estate hospitals, and they have increased to 141. Endeavour has been made to encourage group hospitals because it is believed that a large hospital serving several estates is more economical and likely to be better equipped and there would be competent staff than in the case of a small individual estate hospital; in some instances the group hospital system is working satisfactorily, but in others want of friendly cooperation between managers and lack of businesslike organisation and control has caused the various contributories to break off their connection with a central establishment and start individual hospitals .[46]

Chart 13 below reflects the scale of the provision of arrangements of hospitals and estate doctors by the planting industry in the Federated Malay States. With the exception of one estate with about 200 hospital beds, most estates were equipped with a range of 10 to 50 beds.



Source: Federal Council, Federated Malay States. 22 June 1916, pp.C39-42. See Table 18 of Appendix B of Annex A for further details of individual Estates.

By 1918, the rubber estates provided a total 7057 hospital beds served by 45 doctors (see Table 18 of Appendix B). With the exception of about eight estates that were attended by resident doctors, the majority of estate hospitals relied on peripatetic or visiting medical practitioners. Depending on the size of the estate's labour force, its

[46] *F.M.S.A.R*,1912. p. 4.

proximity to the urban centres or the commitment of the individual plantation manager to healthcare, such visits ranged from daily routines to monthly visits (See Table 18 of Appendix B). Commending the efforts of the planters, the visiting Undersecretary of State for the Colonies, Ormsby Gore reported:

> The health of labour on the estate is well cared for, and very large sums of money have been spent by the rubber companies in anti-malaria measures, such as draining, oiling, quinine prophylaxis etc. Quite apart from the provision available in Government hospitals there are 156 estate hospitals in the Federated Malaya States and 27 in Malacca provided and maintained by the plantation companies for their labourers. Many of these hospitals are admirably equipped. These are inspected annually by the Government Health Officers.[47]

Gradually, the estate hospital services were also opened up to the surrounding villages. While those with minor ailments were treated in these facilities, the more serious cases were usually sent to the nearest town hospitals or to larger establishments in Singapore or Penang.

The private initiatives of the plantation managers however did not seem to address the high mortality rates in the estates. The public health infrastructure established by the estates were considered skeletal and unregulated. A report on the Bukit Rotan Estate Hospital by government health inspectors found the institution which served 5,000 coolies from twenty estates, had only 65 beds, below the minimum requirement of 250 beds. The report continued:

> It seems to me that the law will have to be a good deal more stringent and much more strictly administered unless these estate hospitals are to become a farce[...]Nothing short of stopping labour supplies or vigorous prosecution will induce these managers to meet the responsibilities of their positions.[48]

From similar reports, Manderson concluded the substandard quality of estate hospitals provided by negligent planters who had to be constantly monitored by state regulators.[49]

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[47] *Report by W.G.A. Ormsby Gore, Undersecretary of State for the Colonies on his visit to Malaya, Ceylon and Java*. 1928. p. 40.
[48] Selangor Secretariat Report. 289/1911. f.7.
[49] Manderson. *Sickness and the State*. pp.145-6.

Under pressure from the Madras administration, where most estate workers were recruited and transported from, the authorities suggested replacing of estate hospitals with more centralised establishments. Seeing the responsibility of the general health of the worker as part of the employer's jurisdiction, the government felt the latter should bear the financial cost as well.[50] This suggestion raised substantial discussion in both the plantation community and the newspapers. Aghast with the increasing demands without the accompanying support, the planters felt vindicated. The PAM's Chairman H.M. Darby thought aloud on the virtues of the heavy commitment of the planters to estate hospitals which should be the responsibility of the government (citing the case of Ceylon) since these facilities served a wider public. He felt such demands to be unjust as "why should those who put money be heavily taxed."[51]

With the support of prominent European doctors, the planters argued that large centralised hospitals according to government specifications would divert resources more towards curative rather than preventive measures. While these institutions might offer major surgeries and conduct clinical investigations, they were expensive undertakings requiring highly qualified surgeons and bacteriologists who were rarely needed in the estates.[52]

Dr Rattary, an estate medical officer, explained to the Malacca Planters' Association the limitations of prioritising on estate hospitals and urged for greater preventive measures in its place:

I want to ask you whether any scheme of centralising hospitals paying $3, $5 or $50 per acre is going to prevent these diseases. As long as central hospitals exist to collect a proportion of the sufferers from malaria and distribute them again and as long as nothing is done to get rid of, or at least reduce the malaria carrying mosquito[...]no progress can be made. As long as those who have been relieved of their hook worms are sent back to their dwelling places where insanitations run riot, and as long as 75 percent of immigration population is free to bring in further infection[...]no progress can be made[...]as and so long the coolies whom you stamp as lazy or malinger will remain as burdens of expense to your estates[...]as long as central hospitals exists for the reception of the labourers, who are suffering from

[50] "From the Undersecretary to Government Federated Malay States to Secretary Planters' Association." *T.M.* 10 January 1918.
[51] *M M.* 13 February 1913
[52] *M.M.* 7 February 1913.

dysentery, but are not made attractive nor even possible for the labourer's wife and children, no progress can be made.[53]

Furthermore, it was also felt that central hospitals would be too distant for comfort for the worker and his visiting family members.[54] Added to this, these facilities would not automatically increase the availability of hospital beds in proportion to the estate labour force. On the contrary, planters estimated a possible increase in cost of staffing estate hospitals if they were to be modelled according to the framework in India. To them, would result in an emphasis on the role of the middle grade officers instead of the more junior counterparts, who commandeer not just lower salaries, but could also be more economically deployed.

Instead, the PAM argued the current practice employing resident dressers supervised by fully qualified visiting doctors had ensured favourable results similar to the small cottage hospitals in England under the charge of trained nurses instead of doctors. In a note to the Madras government, the Association explained:

"[...]that proper treatment in hospitals is not a panacea for reducing the mortality amongst the population and it may confidently be asserted that even visits twice a day to every patient in estate hospitals by European doctors of the highest qualification[...]Prevention will not be brought about by increasing the hospital staff on estates, but only by government tackling problem with a view of eliminating infectious diseases not only for the benefit of estate labourers but for the whole population.[55]

The planters insinuated that the state had no right to impose new regulations on the estates since the authorities had themselves been slow in the provision of health services. As claimed by the editor of the *Malay Mail*: "I shall be more impressed by the action of the government when I see it making some attempt to deal with the rural population in this country and not confining its efforts simply to the towns."[56] In view of the staunch opposition, the colonial authorities readjusted its policies to institutionalise the management of estate health.

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[53] *T.M.* 30 May, 1918.
[54] This argument was made by Nixon Rasumgan during a meeting of the Malaccan Planter's Association. *M. M.* 30 May 1918.
[55] *Federated Malay States. Federal Council Proceedings.*1918"Letter from PAM to Chief Secretary, 27 December 1916." p.C.45.
[56] *M. M.* 7 February 1918.

This opportunity came from the scheme adopted by the Malaccan District Planters Association on pooling resources for public health works and the establishment of hospitals. Several larger plantations came together to set up a local health board comprising plantation managers and represented by government medical and agricultural officials.[57] As described favourably by the Colonial Medical Services:

> The scheme under which the Malacca Agricultural Medical Board (Board of Planters) has grouped and assessed the whole of the estates in Malacca, engaged six medical officers and stationed them at convenient centres, and divided the medical charge of the estates amongst them, has proved a success, and is partly responsible for the drop in Malacca's death rate. Some of these medical officers have done good preventive work. The system under which each estate makes its own arrangement for medical attendance still prevails in Province Wellesley and the Dindings. It sometimes results in superficial attention from visiting practitioners, who may live far from the area, and too busy to do the work properly.[58]

Empowered to collect from the various plantations a cess in proportion to the size of their estates, the board was charged with carrying out anti-malarial works around public areas as well as establishment and maintenance of medical facilities.

By sharing out public responsibilities, the scheme seemed able to address the concerns of the planters. In principle, existing estate hospitals could continue to function alongside new hospitals, and the cost of these hospitals could be distributed to other plantations within the designated local board.[59] Furthermore, this board would be able to cover a larger land area than the individual efforts of the estates in its public health works.[60] As such, the proposal for broader, and institutionalised application of the scheme across rubber estates was met with little resistance. An elaborate version of the Malaccan project was being drawn out by the government by 1921 consisting the formation of various local health boards to be supervised by a Central Health Board, working closely with the Public Works Department, the Agricultural Department and

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[57] *Malacca Administrative Report*, 1920. pp.221-222.
[58] *S.S.A.R.* 1925. p. 9.
[59] According to the new enactment, a committee was appointed for each hospital charged to collect funds contributed by plantations in addition to a basic amount provided by the Central Health Board. *T.M.* 9 July 1930. A larger pool of funds was supposedly catered for the development of hospital infrastructure. including specialist treatments. This would in turn provide opportunities to obtaining more accurate information of health statistics. Ibid. 22 January 1930.
[60] PRO/CO/717/ 49. "Federal Council meeting 8 March 1926. Health Board Bill". pp. 487.

the Malarial Advisory Board.[61] In his despatch to the Governor in 1926, the legal Advisor described the Health Board Enactment: " somewhat bold piece of experimental legislation to provide machinery for the general improvement of health conditions and the clearing up of unhealthy areas."[62]

Under the new policy, large estates, defined as those more than fifty acres, which had been certified to have undertaken the necessary public health work, were exempted from financial contributions or cess to their local health boards. Nonetheless, they would still be required to bear part of the administrative costs of these bodies. The various local health boards would in turn conduct surveys into the districts to determine the scope of the public health works to be levied and the expenditure required.[63] These Health Boards have been commended by historians crediting the colonial government for having reined in the planters to take a larger role in the provision of health for the labourers. As Parmer puts it: "The Health Boards scheme was an ambitious and praiseworthy attempt to cope with disease on estates by providing medical services, both preventive and curative, on a systematic and comprehensive basis. Had it succeeded, many of the thousands of workers who died would have lived longer." [64]

But, the friction aroused when a semi-private scheme became a legally mandatory policy under the Health Board Enactment. To begin with, its implementation became an administrative nightmare. Complaints of the delays and confusions were common on top of the difficulties in seeking willing public personalities and industry leaders to sit on the committee of these boards. The main problem however lay in the persistent unhappiness over the management of public health works in "common areas." In spite of the exemption from footing the cost for public health works in these lands, the representatives of larger plantations repeatedly criticised the Health Board's apparent failure to effectively incorporate the non-estate lands into the enactment.

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[61] *T. M.* 22 January 1930.
[62] PRO/CO717/86/3: "Enactment No. 20 of 1932 The Health Board Dissolution Enactment." 1932.
[63] PRO/CO273/56/11: "Ordinance 12 of 1930 Malacca Agricultural Medical Board Assent."
[64] Parmer. "Estate Workers' Health in the Federated Malay States in the 1920s." *The Underside of Malaysian History*. p. 192.

In the various plantation association meetings, frustrated members related their meticulous anti-malaria efforts of drainage and oiling were repeatedly thwarted by choked ravines, stagnant pools, abandoned fields in outside their premises.[65] These were usually found in government owned lands like railways and those of the Public Works Departments, smaller non-European plantations with little regards for public health and neighbouring kampongs. It seemed to them that the board was unwilling and unable to effectively rope the other government departments, smallholdings or villagers into the scheme. The difficulty in incorporating the substantial number of small estates into the Health Board Schemes is reflected in Table 19 of Appendix 2 of Annex A. While they occupied only about 81,819 acreages compared to more than a million for large estates, there were about 1,615 of these smallholdings in which the board had to negotiate.

Hence, the planters thought that the spotlight on merely the larger estates alone as the cause of estate health problems was both unfair and counterproductive. Explaining the limitations of the scheme to a PAM meeting, Dr Waugh Scott, a private practitioner, felt efforts in malaria prevention would be futile when "Just over a boundary, [the ravines] run into a kampong area or a small rubber holding, or a bendang which interferes with natural drainage. At present there is no power by which we can ever compel people to drain to the natural full the next nearest river."[66] Facing mounting grievances from plantations managers as well as complications arising from the scheme, the government decided to abandon the policy by rescinding the Central Health Enactment in 1932, barely a decade after it was boldly implemented. Attributing the failure to mainly the unforeseen Great Depression, the colonial authorities reported:

> During the year, every effort was made to preserve the framework of schemes under the Health Board enactment for visiting by private medical practitioners but owing to the severe economic depression in the industry, progress was difficult and it was necessary from time to time to modify schemes and the recommendations for hospital services consequent upon frequent alterations among labour forces on the estates.[67]

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[65] PRO/CO717/86/3: "Enactment No. 20 of 1932 The Health Board Dissolution Enactment, 1932."
[66] *T.M.* 28 September 1927.
[67] By the time of its dissolution. the Central Health Board incurred a deficit of $62,749.34 Straits Dollars of which about $46,648.29 consisted of uncollected cess. *FMSAR.* 1925 (SOAS Library) p. 25.

However, the issue of financial contributions was the fundamental weakness of the scheme. This was already seen as a potential problem even as the scheme was first enacted in Malacca where the Health Officer expressed his reservations for the Board to maintain healthy finances in light of the fluctuating rubber prices.[68]

Citing the reason of haste for the failure of the Health Board Scheme, Dr G.V. Allen felt nonetheless the importance of the gradual evolution of an estate health system instead of a top down imposition of laws by the authorities. Giving the analogy of the ball being allowed to roll gently with an occasional push, Allen felt the strength of the medical service in Malaya lay in its gradual development, "step by step and in the past each step had been an advance." Paying tribute to the initiatives of the plantations, he observed:

> Estates were themselves slowly forming groups and by example of other groups with perhaps a little pressure from Labour and Health Departments were starting to realise the value of Health to their interest. Travelling dispensaries were going quietly about their work on elevating the rural population in Western medicine and death rates were falling, but for the more resolute this was too slow especially as they had been impressed with the health organisation on estates of other countries which looked perfect and so we tried to emulate them by constructing a health Branch[...]The notions undoubtedly were excellent, but owing to the disregard of the principle of effecting changes slowly, it collapsed, and the lesson served is legislation cannot succeed in an atmosphere of freedom engendered by the British.[69]

By the repeal, the government retreated from attempting to organise the planters back into its regulatory roles through the various Estate Health legislations. At the same, the colonial health services also took over the roles of the local health boards in public health work.[70] Nevertheless, remnants of the Health Board schemes were still operative in individual districts and states by the late 1930s. But, as the Protector of Labour reported, any attempts for its revival was futile:

> The group hospitals fall into an intermediate position between separate estate hospitals and the medical services provided by the Boards in Kedah and Malacca. In some districts the group hospital services include: special visiting dresser and mosquito inspection. During the year nothing was attempted in the way of amalgamating or extending groups though in three different districts. Some attempts were being

[68] *S.S.M.R.. 1920.* p. 34.
[69] *M. M.* 25 January 1934.
[70] PRO/CO717/86/3: "Enactment No. 20 of 1932 The Health Board Dissolution Enactment, 1932."

made to tackle common health problems but the memory of the expense of the previous health boards in the Federated Malay States still prevents any enthusiasm for common action.[71]

However flawed the administration of these hospitals appeared to government inspectors, it must be remembered the network of estate hospitals was largely the efforts of the plantation community. Aside from their regulatory functions, the colonial medical services were unable to match the scale of the provision of these medical facilities to the coolies that the planters had established. Table 20 of Appendix 2 of Annex A shows the extent of provision of estate hospitals in the Malayan Peninsula. Translated into actual figures, this meant that an estimated 162,290 estate workers were served by 223 hospitals around the plantations of British Malaya. The importance of these hospitals was further recognised by the government in engaging the assistance of the estates in the provision of hospital facilities for casualties in the event of war in the region.[72]

The failure of the local health board attested to the role of which the understanding of malaria played in determining the relationship between state, capital, property and society. In the name of mosquito eradication, the plantation community had compelled the otherwise reluctant colonial authorities to assume broader public health responsibilities in common areas. The last section will discuss the extent in which the discourse of malaria was further strengthened by planting interests to be the most fatal disease in the colony.

Pundits and Philistines: The Control of Malaria

Toasting to the memory of Patrick Manson and Ronald Ross at the annual luncheon at the Ross Institute, Mr Eric Macfayden, a director of Harrisons and Crossfields, with long experiences in Malaya, described himself as:

An unscientific person who, in a company where the pundit and philistine mixed, was glad indeed to see among the powerful scientific intelligences a number of plain and honest planters' faces[...He] proceeded to describe the triumphant progress, which he himself witnessed of anti-malarial work in British Malaya, and described in detail the development of rubber planting on the alluvial plains of the west coast of the peninsula where anti-malarial measures had created conditions inhibiting the reproduction of the flat land malaria carrying mosquito. Within the lifetime of his listeners, he declared, an almost derelict community

[71] *S.S.A.R*, 1938. Vol 2. Annual Report of the Labour Department, p. 66 (SOAS Library)
[72] PRO/CO273/662/5. "Extract from Shenton Thomas Budget Speech 18 Nov 1941."

has blossomed out into one of the most prosperous and progressive leaders of the British Colonial Empire.[73]

Another "unscientific person", V.S. Sastri, the Indian delegate appointed to investigate the conditions of immigrant labour in Malaya noted in his report: "The complete control of malaria is perhaps one of the most remarkable public achievement in Malaya, and its success is as noticeable on estates as anywhere."[74]

An understated legacy of the planters in British Malaya was their contributions towards the moulding of the study of malariaology and the application of anti-malaria preventive public health works. Their roles in mainstream historiography on malaria has however been sidelined by the emphasis of prominent personalities and research institutions like the London School of Medicine and Tropical Hygiene. The portrayal of the one-way absorption by industry of biomedical knowledge and practices from the academia and governments should in this case be reviewed. In spite of the generous public acknowledgements and tributes to malaria research for lowering death rates of workers in the rubber estates, it was the plantations that had expanded the application of knowledge in routine preventive health work. In many respects, by constantly engaging malariologists and parasitiologists to combat malaria in their estates, the plantation managers inevitably provided the avenue for the development of the science of malaria control. Acknowledging its limitations in this aspect, the colonial government felt the importance in securing the cooperation and wider participation of colonial civil society, especially the planting community. As the Senior Health Officer of the Federated Malay States, A.R. Wellington put it:

The policy of Government with regard to the control of malaria in the Federated Malay States may be described as one which aims at the utilisation of all relevant forces, government and private, to the end that advantage shall be taken of all useful factors, so that the eradication of the disease shall be economically affected. Government medical officers, medical officers employed by commercial companies, entomologists, engineers and others have worked side by side in the elucidation of the problem. It is true perhaps that each worked in friendly rivalry in the investigation of his own particular field of enquiry, but each published his results either at the meetings of one or other of the local boards composed of officials and non-officials or in the journals of the various medical or scientific societies[...]There are other estate medical officers and private practitioners who helped in the elucidation

[73] *S.F.P.* 24 May 1938.
[74] V.S. Srinivasa Sastri. *Report on the Conditions of Labour in Malaya,* 1937. p. 8.

of the problem and whose names are unknown outside the country owing to the fact that their researches and findings were published locally.[75]

These methods of anti-malaria control, ranging from the prescription of quinine to the drainage and oiling were actively debated and disseminated within the industry's magazines and journals, in addition to the newspapers. With the cooperation of the Malaria Advisory Board and the various plantation bodies, extensive public health advertisements were placed in the publications of the journals of the rubber associations. Articles like "Anti Malaria Measures",[76] "Jungle and Malaria",[77] "Quinine is the Remedy for Malaria",[78] "Why don't we stop it",[79] and "Why risk it",[80] were published in several plantations bulletins like the *RGA Bulletin* and *The Planter* and reprinted and translated in local English and Chinese language newspapers.

The literature of malaria in the rubber industry in Malaya covered from the technical to the popular. Detailed publications on the species of mosquitoes, mathematical recommendations of widening drains, the types of oiling to be used for stagnant water were accompanied by more straightforward reminders on the use of mosquito nets during bedtime and restrain from clearing jungles.[81] The interest generated by the industry was spread to the rest of the colonial civil society with constant attention by the media of malaria in addition to malaria epidemics within Malaya and around the

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[75] A.R. Wellington. "The Ways and Means adopted by Government for the Control of Malaria in the Federated Malay States", *Malayan Medical Journal*, 1924, No.3. p. 16

[76] This advertisement summarised the policy of the Federated Malay States with regards to anti-malaria measures whereby every land proprietor had the legal responsibility in carrying out the necessary public health works upon his land. *Annual Report, Malaria Advisory Board.* Appendix A. p. 8.

[77] The particular note warned of the fallacy in the idea that jungle causes malaria and therefore ravines should be cleared of jungle and secondary growth. Unless estate owners were willing to drain and oil the ravines completely, clearing the undergrowth would aggravate the incidences of malaria infections. Ibid. Appendix B. p.9.

[78] Ibid. Appendix C. p. 10

[79] Explaining the rationale for the priorities placed in anti malaria measures, this advertisement recommended the use of mosquito curtains, smudge sticks, prescription of quinine daily, sending infected workers to the hospitals and keeping them there until they were certified to be free from parasites. Ibid. Appendix D. p.11.

[80] "Why risk it" contained recommendations of using mosquito curtains, the placement of smudge sticks under chairs and tables, the need to keep the houses properly cleaned in addition to making periodic inspections of anophelines in the gardens. Ibid. Appendix E. p.12.

[81] For articles in the Malayan Medical Journals, see: M.Hariharam. "Malaria", "Gonorrhoea". *Malayan Medical Journal*, 1924, No.1, pp.8-10, T.S. Macaulay. "Inside View of Estate Health: Smouldering Malaria," *Malaya Medical Journal*, 1924,, No 2, pp.11-12, and M.Hariharam. "Prevention of Malaria," Ibid. pp.12-15.

region.[82] Claiming the importance of malaria control, the editorial of the *Singapore Free Press* commented:

The [League of Nations Conference on Rural Hygiene in Bundung) laid stress to the methods of control, which have been successfully applied in many parts of Malaya, and it is here where the general population must be persuaded to help in the destruction of breeding places. Where they cannot be persuaded, they must be compelled[...]What is mostly needed however is more propaganda, for without it the full cooperation of the general public cannot be secured. A general policy of compulsion would require a large army of inspectors.[83]

Malariologists like Watson were also keen to preserve the interest and more importantly, the priority given to malaria by the lucrative rubber industry.[84] Apart from making available his time for meetings in estate associations and the Malaria Advisory Board, he lobbied for the recognition of the science within the community. With the support of the Malayan newspapers, Watson personally appealed to the local business community for donations for the Ronald Ross Funds to support the retirement of the latter as well as the maintenance of the Ross Institute.[85] In both Watson's statements and newspaper editorials, the planters were told to be grateful to Ross's contributions to Malaya's prosperity where:

If we had dropped all methods of preventing malaria devised as a result of Sir Ronald Ross's discovery, it would shut down the naval base, it would [have led] to appalling death rates in Singapore, Kuala Lumpur and other towns and it would paralyse half the rubber estates in the colony."[86][...]We carried out researches not in laboratories alone, but in jungles and swamps, on plantations and kampongs and mines. We found many strange things[...]We built up a knowledge of the prevention of malaria based on scientific discoveries, without which it would have been totally impossible to create the prosperous Malaya we see today.[87]

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[82] Malaria became part of the health talks on radio programmes from the Singapore based British Malayan Broadcasting Corporation by the late 1930s. See: *S.F.P.*. 30 March 1939.
[83] *S.F.P.* 12 January 1932.
[84] See: Malcolm Watson. "Sir Ronald Ross and Malaya", *British Malaya*, October 1932. pp. 133-4. His main contribution to the study was: *The Prevention of Malaria in the Federated Malay States: Twenty Years of Progress* (London: J. Murray, 1921).
[85] Through the publicity of the local newspapers, Watson managed to raise a total of $30,000 from readers in British Malaya for the retirement of Ross who: "in spite of a life, or perhaps a life devoted to the welfare of his fellow men, was a poor man, and for ten years before he died, he was seriously worried by the fact his widow would have been very ill provided for in the event of his death." *S.F.P.* 18 November 1937.
[86] *S.F.P.* 18 November 1937.
[87] Ibid.

In effect, the construction of the discourse of malaria eradication reflected the undercurrent of common interests between the planting community and sections of medical practitioners involved in vector control. By platforming malaria as the deadliest obstacle to progress brought about by plantation agriculture, this section of colonial society concurrently utilised the disease to propagate their agendas and entrench their social positions. To the malarialogist, the mosquito was the key to underline the importance of a new profession centred around a multi-disciplinary approach of curative and preventive sciences. To the plantation manager, aside from increasing labour productivity, malaria control became framed as a testimony to his conquest of nature and his paternalistic care for his workers.

Conclusion

This chapter has demonstrated the role of estate health in its relationship between the growth of the rubber industry, the organisation of planting interests and the demarcation between private and public responsibilities. Pioneering the penetration of the Malayan hinterland, the planters in Malaya became prominent by the early 20th century because of the rubber boom. While the state was instrumental in encouraging this development with generous allotment of land and the extension of transportation infrastructure, it was less forthcoming in providing for the growing number of the predominantly Tamil immigrant coolies. Instead, it expected the estates to assume this responsibility.

Although there were outstanding cases of estates with appalling working and living conditions for coolies, it was the plantations that preceded the state in the provision of medical facilities. Without access to public hospitals and clinics, plantation managers had to establish their own facilities. Gradually, an emerging network of estate hospitals with sizes ranging from 10-100 beds, staffed by dressers under either resident doctors or visiting practitioners, was developed. Tailored to the concept of "cottage hospitals", these medical centres dealt with common ailments while more serious afflictions were transferred to the main hospitals in the towns. In addition, informal levels of cooperation between estates were also formed to economise on healthcare provisions. Eventually, these services were made available to the surrounding populations outside the plantations.

Moreover, through their preventive health works, especially in the area of malaria control, the estates provided the colonial medical fraternity sites to develop the discourses on tropical diseases. Entomological understanding of vector strains of malaria accompanied by methods and techniques in preventive health work as well as the dosage involved in the prescription of quinine were actively discussed by both health professionals and estate managers. To a large extent, aside from the high death rates, the importance of plantation agriculture in the colonial economy enabled the planters to elevate the threat of malaria to the territory. In the spectre of this disease, they drew public attention towards their roles in Malayan society as not merely cultivators, but pillars of progress and modernity in the British Empire.

While the efforts of the planters to reduce mortality rates in the estates remains debatable, its involvement as part of colonial society was seemingly more prominent in contesting state discourses through public health. Through the various plantation associations, planters compelled the colonial authorities to assume more responsibility towards estate workers. The planters had not only contested public health regulations but also scrutinised the operations of the colonial health services, particular the government administered quarantine centres at the ports, which were crucial in affecting the supply of immigrant labour.

Even as their hospitals were subjected to increased scrutiny, the estate managers and owners were quick to rebuke the colonial medical services for not providing sufficient general healthcare to estate workers. In terms of preventive health works, the various plantation associations were also able to attribute the presence of malaria infections to the general negligence of the authorities of public areas. In turn, the notions of estate health gave the planters stronger impetus for demarcating spaces of private property against public spaces. The failure of the Health Board scheme was indicative of the extent of opposition from the planters against shouldering more public health responsibilities, which they felt should rest on the state. In this respect, underlying the articulations of the merchants and planters were the zealous emphasis on unhindered flow of capital and labour, a flow in which it was strongly felt that the colonial governing machinery should facilitate instead of restrict.

Meanwhile, in the Malay rural heartlands outside the fences of the rubber estates, an American based philanthropy was beginning its international drive for disease eradication and health education in the kampongs. While malaria preoccupied the estates, the hookworm would become the showcase of the Rockefeller Foundation's International Health Board in the next chapter.

Chapter 4
Spectators of Hookworm: Rural Health & the Rockefeller Foundation

The Malays of the rural areas remained purebred. Socially they mixed hardly at all with non-Malays, and were exclusively farmers with no interest in trade and craftsmanship[...]Malaya abounded with various debilitating endemic diseases like malaria and yaws[...]As often happens to a community subjected to continuous exposure to these diseases, the rural Malays developed a certain amount of resistance. They survived, but their energy was depleted. Rendered weak and dull by lack of blood and frequent bouts of fever, they were disinclined to work more than just necessary. The effort to plant and reap padi, which occupied two months of every year, taxed their strength. They had no more energy left to earn a better livelihood, or to teach themselves new skill[...]Their will to progress, never great because of lack of contact with the outside world, became negligible. Soon they were left behind in all fields. The rest of the world went by, and the tremendous changes of the late 19th and 20th centuries took place without the rural Malays being even spectators.

Dr Mohammed Mahathir. *The Malay Dilemma.*[1]

Worms in a bottle have little persuasive appeal to the average citizen of Malaya. But worms in his own dejecta stir the imagination of even the most sceptical person and frequently arouse enough apathy to lessen his resistance to the idea of spending money and labour for a sanitary latrine.

Rockefeller Foundation field representative Dr. Paul Russell[2]

Introduction: Stirring the imagination

In the centenary of the establishment of the King Edward VII Medical College in 1905, the writings of one of its prominent alumni, Dr Mohammed Mahathir were prominently featured. Subsequently assuming premiership of Malaysia in 1981, the obstetrician turned political activist used the supposed indolent Malay racial attributes as justification for affirmative action. The impetus to change the "lazy Malay mindset" came not just from the state as would be commonly supposed, but the Rockefeller Foundation (RF). Convinced of the anaemic effects of sickness as the paramount cause of backwardness of the rural populations, the Foundation embarked on an ambitious global drive in disease eradication. Using ankylostomiasis, or hookworm infection as a template, the RF representatives sought also to instil greater public consciousness towards the preventive health.

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[1] From H.T. Ong. "A Doctor's Duty is to Heal the Unhealthy: The Story of Tun Dr Mahathir Mohammad". *Annals* 34:6 (July 2005): 45C-51C. pp. 48-9. See also: Mohammed Mahathir. *The Malay Dilemma* (Singapore: Times Books International. 1970) pp. 16-31

[2] Rockefeller Archives Centre (Henceforth known as RAC). Box (B). 210, Record Group (R.G).5.3. Series (S).2. Folder (F): 2590. Collection (C):473H. Paul Russell. "The Straits Settlements Rural Sanitation Campaign. Reprinted from The Malaya Medical Journal. 4(3)1928. pp.79-83.

Aside from funding the Singapore based Medical College and the League of Nations Far Eastern Bureau's Epidemiological Unit, the RF was extensively involved in the rural health of British Malaya between 1914-1928. Its activities in British Malaya can be discussed along two stages. The first entailed the preliminary attempts of its representatives to impress upon a suspicious colonial medical service on the severity of ankylostomiasis in the region with preliminary surveys undertaken between 1915-1919. This led to the second stage in the Straits Settlements Rural Sanitation Campaign from 1926-1928 covering the rural areas of Malacca, Penang and Singapore. Throughout the two stages, three issues of public health would surface. They are namely, the framing and prioritisation of ankylostomiasis, the emphasis of mass education, the development of public health facilities like latrines and the institutionalisation of rural health units.

The major players from the IHB driving the Malayan project were Dr S.T. Darling, Dr M.E. Barnes, Dr Paul F. Russell and Dr Victor Heiser. The records of their correspondences, diaries, unofficial and official reports, in turn enables a more comprehensive assessment of the RF works in British Malaya. The experience of the IHB officials in turn serves in gauging the social negotiations of American corporate philanthropy with both the colonial administration and larger society. Aside from historicising the American presence in the territory, the study of the RF's experience's here is crucial in providing more qualified assessments of the notions of American hegemony in different contexts.

"Americanism versus Imperialism"

With its extensive outreach in a short span of its establishment in 1913, the RF was instrumental in defining the phenomenon of global philanthropic enterprise. From scientific and medical research to social development, the foundation had either offered expertise or/and funds to institutions and projects. Given its massive projection, RF activities could not be regarded merely as altruistic and disinterested. The legacy of the foundation has been associated with the commitments of John D. Rockefeller. With the wealth from his business empire built from the oil industry, Rockefeller was able to realise his ideals through the foundation focused more on interminable social investments over "alms-giving". As Soma Hewa and Philo Hove observe: "Philanthropic giving as now defined has much broader objectives than those of charity.

It essentially involves community mobilisation and organisation of collective energies and resources for the purpose of the common good."[3]

These activities have in turn been framed along higher ideals of American society. In distinguishing between Americanism against that of Imperialism, Andrew Carnegie saw international philanthropy as a part of Americanism, "a moral force of higher civilisation grounded on certain fundamental principles [where] the government derives its just powers from the consent of the governed and that all men are created equal." To him, European imperialism signified little more than "brutal physical strength."[4] These values were highly internalised by the RF representatives. In explaining the foundation's public health projects, Heiser trumpeted a mutually beneficial outcome of American philanthropy in the world:

An important outcome of American entrance into the field of tropical sanitation is the reflex stimulus which has been produced in the United States...The impetus which sanitation in the Orient has received during the past years has contributed greatly to the well-being of mankind, and America's efforts, which have been made largely through altruistic motives, have added no small share.[5]

In "Americanism", on the other hand, detractors have critiqued the RF as another manifestation of American politico-corporate hegemony. The Foundation's projects were considered as an insipid acceleration of the process of the imposition of capitalistic modernity and socio-politico dependency on the Third World. In the words of Hewa and Hove:

When Western philanthropy arrived in Asia during the 20th century, the region was largely under Western Colonial rule. The political institutions, the state bureaucracy and the social agencies introduced by foreign rule were based on a paternalistic attitude which has prevailed till this day. It was a conspicuous system of unequal relations in which the ruling agencies whether national government or local authorities assumed a custodial role over the masses by effectively eliminating long standing social relations.[6]

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[3] Soma Hewa and Philo Hove (eds). *Philanthropy and Cultural Context: Western Philanthropy in South, East and Southeast Asia in the 20th Century* (University Press of Michigan, 1997) p.4.
[4]Rodney Sullivan and Reynaldo C. Itelo. "Americanism and the politics of health in The Philippines"Ibid. p.4.
[5] Victor Heiser. "American Sanitation in The Philippines and its influence on the Orient" *Proceedings of the American Philosophical Society*, Vol.57, No.1 (1918):60-68. p. 68.
[6] Hewa and Hove (eds). *Philanthropy and Cultural Context*. p.5.

In explaining the projection of US Imperial power, David Slater explains the faith in the primacy of American values (like those expressed by the RF) gave the US "an enduring invasiveness or desire and capacity to penetrate other societies and cultures. Being multi-dimensional and intersecting between the psychological, socio-economic, political and cultural realms, the imposition has often been set by a superior power ostensibly saving the other from itself."[7] While the narratives of the Foundation had lionised the personalities and their related works, the revisionist accounts had also tended to tailor their just as uncritically to fit the polemics of American imperial hegemony. The contesting claims have nonetheless straitjacketed the historiography of the RF into binaries of agendas.

Recognising the need for specificity, the historiography of the RF's has also expanded to the examination of the Foundation's activities in individual countries and regions.[8] Outside The American protectorate of The Philippines, little research has been made on the RF's activities in Southeast Asia.[9] Attributing the lack of interest of the colonial authorities of the Malay States in the anti-hookworm proposals, John Farley assumes the RF did not continue its work in the peninsula.[10] Fortunately, the Foundation's legacy did not evade the eyes of historians of Malaya, particularly Phua and Manderson.[11] While describing it as a forum for mass education on hygiene and sanitation, the latter was nevertheless sceptical on the durability of the RF efforts. Her conclusion has however been based solely on the Straits Settlements Medical Reports between 1925-8 instead of a broader assessment of the different contexts in which the campaign was

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[7] David Slater. *Geopolitics and the Post-Colonial: Rethinking North-South Relations* (USA, UK: Blackwell, 2004) pp. 52-3

[8] See: Anne-Emanuelle Birn. *Local Health and Foreign Wealth : The Rockefeller Foundations's Public Health Programs in Mexico, 1924-1951* (PhD Thesis: Johns Hopkins University Press, 1993). William Schneider (ed). *Rockefeller Philanthropy and Modern Biomedicine: International Initiatives from World War One to the Cold War* (Indiana: Indiana University Press, 2004) p. 3

[9] Till date, the only English language work on the pre-1942 IHB's involvement in Southeast Asia is Peter Donaldson. "Foreign Intervention in Medical Education: A Case study of the Rockefeller Foundation's Involvment in a Thai Medical School", *Navarro. Imperialism, Health and Medicine.* Pp.107-126.

[10] John Farley. *To Cast out Disease: A History of the International Health Division of the Rockefeller Foundation,1913-1951* (New York: Oxford University Press, 2004) pp.65-66.

[11] See: Phua. *The Development of Health Services in Malaya and Singapore.* pp. 90-93. Manderson. "Wireless Wars in the Eastern Arena : Epidemiological Surveillance, Disease Prevention and the work of the Eastern Bureau of the League of Nations Health Organisation, 1925-1942" Weindling (ed). *International Health Organisations and Movements, 1919-1939.* pp.109-33. and "Race, Colonial Mentality and Public Health in Early 20th Century Malaya", in Rimer and Allen (eds). *The Underside of Malaysian History.* pp. 206-11.

situated. Without a more detailed appreciation of the RF's philanthropic works, the critical assessment of rural health in Colonial Malaya will not be complete.

Before commencing on the discussion, it is important to clarify the position of the IHB as an institutionally independent organisation instead of another front of American foreign policy as some scholars have suggested.[12] The US government and the RF might have shared similar worldviews, and their representatives were probably personally well acquainted with each other, but it is not certain both parties had collaborated consciously on an institutional basis to cynically advance American political interests under the guise of corporate philanthropy. My examination of IHB archival sources pertaining to Southeast Asia during the Inter-War decades did not indicate the presence of any US government agencies in the Foundation's activities. On the contrary, there seems to be surprisingly no mention of any interactions between the IHB officials and the American diplomats in the various consulates and embassies of these territories.

The Trojan Horse of Public Health

Compared with the economic and administrative centres of the colonial towns and port cities, the British state apparatus was significantly less prominent in the rural heartlands. There were attempts largely made by the British medical officers to implement modern public health programmes like smallpox vaccination, the provision of outdoor and mobile medical dispensaries to even the most inaccessible villages by boats and motor vehicles.[13] The RF quickly noticed this gap when it first established the International Health Commission (subsequently known as the International Health Board or IHB) on 27 June 1913 with the aims of promoting public sanitation and the "spread of the knowledge of scientific medicine" to the world. [14]

[12] See: E.R. Brown. "Early Rockefeller Programmes at Home and Abroad", *American Journal of Public Health*", 66:9 (1976): 897-903.
[13] See: Liew Kai Khiun. "Travelling Dispensaries and Rural Health Visits in British Malaya (1896-1960s)", *Wellcome History*. 30 (2005) p. 8.
[14] International Health Commission, *Annual Report*, 1913. p. 8. (RAC).

In the course of its anti-hookworm treatment programmes in the United States, the Commission observed the heighten public interests in ankylostomiasis, of which diagnosis, prevention and cure were could be easily explained and demonstrated. Consequently, in hookworm, the RF found an avenue to spur greater social consciousness towards the importance of public health where: "people, physicians, state board of health, county, and municipal officers are eager to cooperate in all helpful ways, and that following the treatment and cure of this disease, an intelligent public interest is awakened in hygiene and modern scientific medicine and in practical measures for permanent public sanitation."[15] As such, the IHB saw its hookworm treatments as a Trojan Horse for mobilising communities towards the control of diseases:

The relief and control of this one disease is an object-lesson in the relief and control of disease in general. This one is simple and tangible; the common man can easily understand what it is, and what it means to him as a menace to his health and to his earning power; he knows its whole story; he knows its simple treatment and its one simple preventive measure. Having seen this one disease brought under control and having had the worth of the effort brought home to him, he is prepared to give heed when spoken to about the control of diseases that are less simple and less tangible. [16]

RF officials were convinced that the American experience with treating hookworm infection was also relevant in the tropical zones. On a global scale, the Board mapped its hookworm cartography around:

[...]a belt of territory encircling the earth for thirty degrees on each side of the equator, inhabited according to current estimates, by more than a thousand million people; that the infection in some nations rises to nearly ninety nine percent of the entire population; that this disease has probably been an important factor in retarding the economic, social, intellectual and moral progress of mankind; that the infection is being spread by emigration; and that where it is most severe little or nothing is being done towards its arrest or prevention. [17]

[15] Ibid.
[16] Ibid. p.40.
[17] Ibid. p. 8.

With this map in mind, the IHB announced its global crusade: "To extend to other countries and peoples the work of eradicating hookworm disease as opportunity offers, and as far as practicable to follow up the treatment and cure of this disease with the establishment of agencies for the promotion of public sanitation and the spread of the knowledge of scientific medicine."[18]

Immediately after its announcement, the RF received invitations from eleven governments to conduct hookworm surveys in their territories. Initial priorities were placed on the British Empire with the potential of gaining access of its medical institutions and its vast colonial possessions.[19] London, for its part, was also keen to engage the American philanthropy. In a memorandum to the first Director of the IHB Wickliffe Rose, the Colonial Office stated: "the prevalence of the [hookworm] disease has caused successive Secretaries of State grave anxiety." The memorandum further categorised its colonial territories into three groups, according to the reported severity of infection. The first group belonged to regions in which ankylostomiasis was endemic but preventive measures were already correspondingly established. The Colonial Office felt the RF would find the "ground being already prepared for them" in these places. The second category was in areas where the high hookworm infection rates were attributed to the lack of local resources and general ignorance of the disease, while the last referred to territories where its infections were generally mild.[20]Together with British Guiana, Ceylon and Trinidad, British Malaya was placed in the second category.

"Carrying a heavier burden": The Darling Commission and rural Health

Despite this severe categorisation, there was little concern within both the local medical circles and the larger public awareness on ankylostomiasis within colonial Malaya.[21] Explaining of this apathy, Malcolm Watson indicated to Rose that ankylostomiasis was

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[18] Ibid.

[19] RAC. B.38. RG:5. S:2. F: 227. "Summary of proceedings at a conference between the Colonial Office and the Representatives of the Rockefeller Foundation." 10 June 1921.

[20] Ibid. "Ankylostomiasis: Memorandum for Dr Wickliffe Rose, prepared by the Colonial Office."

[21] RAC. B.50.R.G.5.S: 473.F.318. See also: The Rockefeller Sanitary Commission for the Eradication of Hookworm Disease. *Hookworm in Foreign Countries* (Washington D.C.: Office of the Commission. 1911) pp.73-4.

of much less importance than malaria in this country.[22] A similar conclusion was reached by the Foundation's officials as well. IHB representatives were of the opinion that anaemia of anklyostomiasis was not to be distinguished from that of malaria as: "The two diseases are so complicated that it is difficult to determine whether or not uncinariasis [hookworm infection] on these estates is a sufficient menace to health to justify a special effort of relief and control. The first level should be directed at ascertaining the facts."[23]

Described as being "not only friendly, but cordially sympathetic," the local authorities accepted the proposed surveys by the IHB comprising of Dr. Samuel Darling, Dr Marshall Barber and Dr H.P. Hacker.[24] Known as the *Uncinariasis Commission to the Orient*, the body was tasked to "determine to what degree Uncinaria infection is a menace to the health and working efficiency of the people in the country under consideration."[25] In the course of their investigations in British Malaya, the Commission microscopically examined the faeces of 3,776 persons from different ethnic groups and occupations and revealed high incidences of hookworm infections among them. [26] Although it acknowledged the prevalence of malaria, the Commission however warned against underestimating the enormity of the anklyostomiasis. A population weakened by malaria, it argued, would be made significantly more vulnerable to hookworm infections of potentially epidemic proportions as: "one would expect hookworms to produce in relation to number, the same amount of anaemia here as when larger numbers are harboured causing measurable anaemia."[27]

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[22] While Rose was personally keen to learn the anti-malaria methods in Malaya which he thought would be useful for the Southern states of the USA. he declined Watson's proposal to set up a centre for studying both malaria and hookworm. Concluding that Rose had to adhere to IHB's mandate of hookworm eradication, Watson recalled he "regretted it was impossible to proceed with the malaria portion of the scheme."
RGA Bulletin. August 1923. p.9.

[23] International Health Board. *Annual Report*, 1914. pp. 17-19. (RAC).

[24] Report of Uncinarisis Commission. *Hookworm and Malaria Research in Malaya, Java and the Fiji Islands* (New York: The Rockefeller Foundation: International Health Board, 1920) pp.12-15.

[25] Ibid. p. 15.

[26] The Commission reported an infection rate of 96.7 percent or 2,188 of 2,262 persons examined at the Port Swettenham Quarantine Centre and 40 percent from post-mortem findings at the Kuala Lumpur District Hospital. In the St. John's Quarantine Camp in Singapore, of 304 faeces samples taken, 66 percent were found to contain the hookworm ova. Ibid. pp. 52-53.

[27] Ibid. p. 91.

In this respect, the IHB found it feasible to frame the treatment of hookworm as part of curing malaria, and elevating its victims from anaemia regardless of prevailing diseases. With this conclusion in mind, the Commission began to place its spotlight on the countryside for any prospective anti-hookworm campaign where:

> In inaugurating a campaign against hookworm infection in a tropical country, it would seem more humane to select for treatment those communities in which the people are carrying the heavier burden of infection as for example among the agriculturalists working in cane, rubber and coffee. The town dwellers are always more lightly infected and their case is not so urgent. [28]

Darling felt the reach of the colonial health service in the rural areas of Malaya was still in a "backward" stage, giving the Board "splendid opportunities" to make further inroads as:

> On first view it would seem that the installation of latrines and the education of the people in their use and in a better personal hygiene requires that the Field workers should remain in the village long enough to have thoroughly impressed the inhabitants with the importance of the preventive aspects of the work. They should not hurriedly leave after merely treating them. Nevertheless, important as is the education of the people in a better personal hygiene, the riddance of great mass of the population of their hookworm handicap is of greater immediate importance. [29]

The emphasis of treatment regimes was considered by the medical officials to be tedious, requiring both constant frequent administration of drugs like Chenopodium and Tetrachloride as well as intensive monitoring of patients.[30] Reviewing these treatment methods, the Medical Report of the Straits Settlements reported: "The only way to stamp out this disease is to teach the whole population, and especially those in the rural districts to use latrines."[31] In recognising the importance of public health education in the rural areas, the opinions of the colonial authorities seemed to be converging with that of the IHB.

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[28] RAC.B.50.RG5. S.2.473H.F:317. Dr.S.T. Darling. "Hookworm treatment questions, treatment in malarial communities and suggestions for conducting campaigns." pp.8-13.
[29] Ibid. p. 16.
[30] *S.S.A.M.R.* 1922. p.39.
[31] Ibid. p. 4.

The Straits Settlements Rural Sanitation Campaign

The selection of the Straits Settlements for the initiation of the IHB's campaigns could be attributed to both the lobbying efforts of the local administrators and the Board's assessment of the suitability of the territories' public health infrastructure.[32] Guided by the fundamental principles of the RF as a philanthropic enterprise instead of a charity, the IHB was keen to function as a supplement and stimulus to the local health services. Both the directors and area representatives were clear the final responsibility was in the state in which the IHB had no wish overshadow. This principle was elucidated explicitly in the Board's Annual Report for 1922:

> From the onset, however the Board has maintained the conviction that public health is essentially a function of government. No private and temporary agency, whatever its resources, could or should discharge responsibilities which by their nature, belong to the constituted authorities of the commonwealth. Private enterprise therefore, may be best employed in awakening public opinion and thereby encouraging state and county officials to establish permanent agencies for health work.[33]

While keen on pioneering public health activities, the IHB was also equally eager to see the localisation and continuity in their projects. In this respect, they would have preferred a comparatively more established medical infrastructure of the Straits Settlements. A successful campaign in the rural territories of Singapore, Malacca and Penang would in turn become beachheads for diffusing the culture of hookworm eradication and that of public health education in the rest of the peninsula where in the words of Barnes:

> In the course of time, as the work develops, I believe it possible to develop contacts which will lead to the extension of our work (if desired) or to the stimulation of health development in adjacent countries [...]A successful work in Straits Settlements would probably be a means of extending such work into the Federated Malay States if the Board were willing.[34]

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[32]Records revealed some interest from the medical officials of the UnFederated Malay States. The Resident Surgeon of Kelantan wrote to Rose expressing interest with IHB progammes on 15 August 1918. Heiser replied that while owing to the exigencies of the war, it was not possible to send a commission, he hope for cooperation in the near future based on the IHB model with the other colonies. However, he stressed the responsibility for these operations should be eventually subsumed by the local government. There were no subsequent correspondences after this note. . RAC. B.69.RG.5.S.1.2.F.995. C.471. "Heiser to Dr Geale. Kelantan." 14 Oct 1918

[33] IHB. *Annual Report*. 1922. p. 6.

[34] RAC.B.233.RG.5. S.1.2.. F. 2973. "From M.E. Barnes to Victor Heiser." 4 July 1925.

The work towards establishing the campaign and the cultivation of supporters, was however not a smooth process. RF's representatives were met with general apprehension from within Malayan civil society. IHB correspondences with the colonial medical services suggested of strong misgivings within the ranks of the authorities. In several letters to Dr. C.L. Sansom of the Federated Malay States, the IHB expressed not only disappointment of being stopped from embarking on joint projects with the local medical services, but also shocked with the certain of their supporters being implicated.[35] In defending the foundation's altruistic motives, Rose noted: "It is fundamental in the policy of the board to do nothing in any country except in the cooperation in [the board's public health] work."[36]

Heiser's diaries revealed more graphically the difficulty in gaining local acceptance of the IHB presence in Malaya as well as the bureaucratic differences within the colonial authorities. His strongest comments were however reserved for the apparent indignities which his field representatives Barnes and Russell had to endure:

> He [Dr Barnes] has a long tale of woe and is thoroughly disheartened and discouraged and wants to return to the United States. The British give him very little social recognition and Dr Russell none whatsoever. They have been going through a veritable hell. Dr Hoops did not help them by introducing them at any club or extending any of the social amenities. Dr Hoops gave him a desk in a miserable crowded office and told him to see Dr Brooke if he wanted something better[...]no help by Hoops or other officials on medical matters[...]The feeling against Americans in this country appears to be very strong. The *Straits Times* publishes vitriolic editorials daily. Dr Barnes has also worried over the illness of his wife and children and is considering sending them home in April. He states that it is great hardship to him to be separated from his family. He has been so depressed that at times he has even considered suicide.[37]

In spite of the difficulties, the IHB managed to secure the cooperation of the colonial medical service in launching the Straits Settlements Rural Sanitation Campaign. In 1925, a landmark agreement on a joint campaign to improve rural health was reached between to two parties. This was followed by a joint survey between the IHB representatives and the colonial health services of the potential areas of cooperation. Completed by September of 1925, the report published at the end of the year made a

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[35] RAC. RG 5.S.1.2 Box 69. F: 995. "Letter from Victor Hesier to Dr. C.L. Samson, FMS , Kuala Lumpur, 19 June 1918.

[36] Ibid. "Letter from Wickliffe Rose to Dr. C.L. Samson. 29 October 1918."

[37] RAC. RG.12.S. 12.1, Box 27 Officer's Diaries Heiser's Diaries. p. 297.

series of recommendations, including: the formation of district level health centres, strengthening of local sanitary departments to tackle soil pollution, greater emphasis in laboratory work and provision of anti-hookworm treatment at quarantine centres and the development of public health education. [38]

The targeted rural population of the campaign was estimated to be at 410,838, making about half the total inhabitants of the Straits Settlements. Of this figure, about 50 percent the numbers of villagers were estimated to be Malays (see Table 21 of Appendix 3 of Annex A). Beginning from January 1926, the campaign would be funded by both the IHB and the government, with the latter increasing its share progressively for the following years.[39] Under the agreement, renewable on a yearly basis, the government was responsible for providing the necessary resources and legal support while IHB carried out hookworm treatment and public education programmes.[40] Starting from Malacca, these activities were planned to proceed towards the Northern Settlements of Penang and Province Wellesley in the second year before shifting towards the rural parts of the islands of Singapore, Labuan and Dingdings. [41]

"Bailing without a sieve": Examinations and Treatments

Apart from coolies from plantation estates and quarantine centres, the campaign extended to the hamlets and schools of the rural districts. Its staff travelled close to 120,000 miles, examining and treating about 56,000 people for intestinal worms. Concurrently, newly formed and pre-existing medical institutions were also involved in the anti-hookworm programme, treating about 400,000 people.[42] In total, 463,522 people underwent such treatment (see Chart 14 below).

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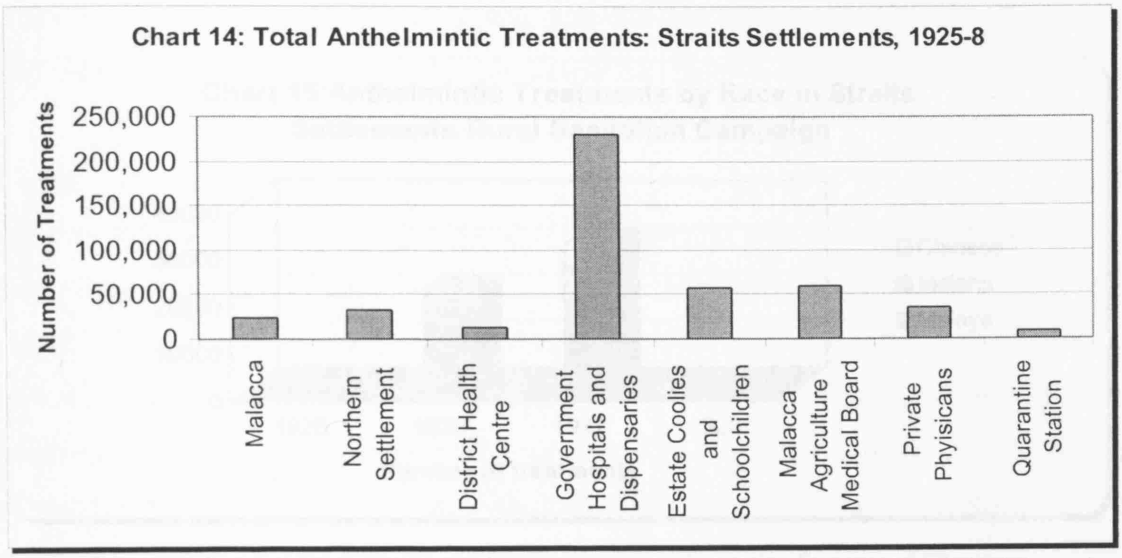
[38] *S.S.A.M.R.* 1928. "Appendix N: "Extracts from Straits Settlements Rural Sanitation Survey and Campaign: Final Report and Tables, 1925-8. pp. 127-8.

[39] The rates were as follows: In the first year, the IHB would commit $21,200 Straits Dollars while the local authorities would foot $14,800. The arrangements would remain the same for the second year before being almost reversed in the third year with the Board coming out with $10,600 and the government $23,400. RAC.B. 211.RG 5. S.1.2, F. 3368. 473 Straits Settlements (1926). .

[40] Ibid.

[41] *S.S.A.M.R*, 1926. "Annex E: First Annual Report of the Straits Settlements Rural Sanitation Campaign, by Paul Russell" p. 101 (Wellcome Library). The joint cooperation between the IHB and the local authorities evidently contradicted Farley's suggestion that: "the Board's encouragement of the status quo by offering hard cash to colonial governments who were unable or unwilling to finance health campaigns from their meagre resources." Farley. *To Cast out Disease*. p. 62.

[42] Ibid. p. 146.



SSMR. 1928. Source: *SSMR*, 1928. "Annex N: Straits Settlements Rural Sanitation Survey and Campaign. Final Report and Tables. 1925-1928. p. 157. See: Table 22 in Appendix 3 of Annex A for details.

The IHB began a process of training campaign staff on stool diagnosis methods covering the mixing, filtration and screening of excreta samples as well as the categorisation and counting of the hookworm ova.[43] Reactions to the treatments however received greater concern for the IHB. In spite of the apparent care in finding appropriate doses for different groups, complications and allergies, some with fatal consequences, occurred during the process.[44] In its 1926 report, the Board stated: "There is no ideal anthelmintic that will kill all hookworms without endangering the host. Therefore a compromise must be made between efficiency and safety, and the relatively small campaign dose is an attempt to emphasize the safety factor without altogether destroying the efficiency."[45]

The complexities of the treatment were in turn defined along racial and cultural habits as well as the geographical localities of the indigenous population treated. In comparison of about 1,800 schoolchildren examined, the report observed higher infection rates among rural inland children of about 41.2 worms per child compared to the villagers along the coast and within the Malaccan town of 31.6 per child and 38.4 respectively.[46]

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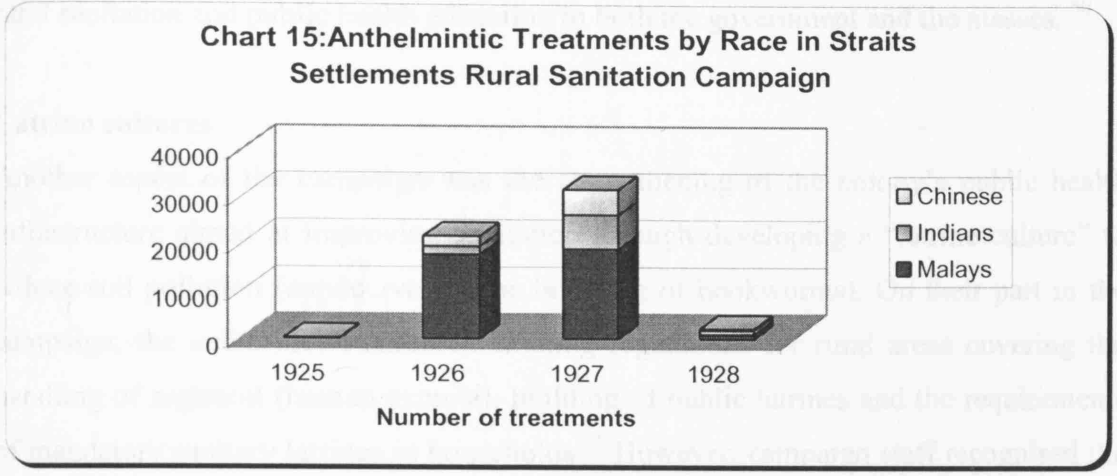
[43] RAC.B.210.RG.5.S.3.F.2594.C.473H. "First Annual Report of the Straits Settlements Rural Sanitation Campaign." 10 January 1927. pp.13-14
[44] *S.S.A.M.R*. 1926. p. 110.
[45] Ibid.
[46] Ibid.1926, p. 107.



Source: Annex N: Extracts from The Straits Settlements Rural Sanitation Survey and Campaign Final Report and Tables, 1925-1928. Table No 33, p. 153. See: Table 23 in Appendix 3 of Annex A for detailed figures.

While the IHB reports expressed satisfaction with and surprise at the enthusiasm for the Malay villagers to the campaign, making up about 70 percent of those treated (see Table 3), it was displeased with their general sanitary habits. Its representatives complained of the absence of any concept of latrines in the Malay and Chinese villagers and their preference for walking barefooted.[47] Without a more discriminate regard for the separation of excreta from the soil, the Board reported such hookworm treatments would be counterproductive as:

> It has been held by some that mass treatments tend actually to increase rather than decrease the incidence of hookworm infection, in the absence of sanitation, by causing a sort of mass diarrhoea" that inundates the whole countryside with viable hookworm eggs and thus results in intensifying the amount of soil infestation with larvae and so the amount of infection and disease in man[…][48] It is of course obvious that so far as eradicating hookworm is concerned mass therapy without coincident soil sanitation is like "bailing without a sieve." The universal use of sanitary latrines is the only possible way of eradicating hookworm infection.[49]

Nonetheless, the IHB did not feel that the treatment campaigns were totally futile. While Russell believed re-infections would return to areas under campaign treatments

[47] Ibid. 1927. "Second Annual Report of the Straits Settlements Rural Sanitation Campaign," 1927. p. 19.
[48] Ibid. 1926, p. 140.
[49] Ibid. p. 140

after one or two years, he felt they had crucially underlined the significance of both rural sanitation and public health education to both the government and the masses. [50]

Latrine cultures

Another aspect of the campaign was the strengthening of the colony's public health infrastructure aimed at improving sanitation through developing a "latrine culture" to reduce soil pollution (conducive for the breeding of hookworms). On their part in the campaign, the authorities reinforced existing regulations for rural areas covering the handling of nightsoil (human excreta), building of public latrines and the requirements of mandatory sanitary latrines in households.[51] However, campaign staff recognised the limitations of legal measures. As Russell noted: "Compulsion in the Kampongs is not feasible. The laws are not so ample as in the gazetted areas and furthermore even with the law it would still not be useful to attempt to force the householders in the kampongs to build latrines against their will."[52]

The installation of latrines was however an easier process in government institutions in rural areas like police barracks, public works offices and schools. Within the end of the first year of the campaign, all such official buildings in Malacca, except schools, were provided with latrines.[53]Similar provisions to hamlets were however more daunting. Of the estimated 20,000 latrines needed in rural Malacca, only 1,316 were built and 259 repaired in the first year of the campaign.[54] A means of trying to persuade the villagers to embark on building latrines was the introduction of a "simple and cheap" (amounting to less than $10 Straits dollars per latrine) model accompanied by "standard instructions, models, tools and materials." The results were however not immediately encouraging. A survey made between 1926 and 1927 of 70 villages and 10,410 households in Malacca, found only 10.9 percent of the houses equipped with sanitary latrines and about 70 percent were completely devoid of any form of sanitation. Nevertheless, Russell saw a silver lining in the last year of the campaign where 800 when latrines were being built by villagers on their own accord.[55]

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[50] RAC.B.210.RG.5.S.3.F.2594.C.473H. "Second Annual Report of the Straits Settlements Rural Sanitation Campaign," 1927. p. 20.
[51] *S.S.A.M.R.* 1926. p.112.
[52] Ibid. p.112.
[53] RAC: RG 5. 1.2. Box 266 F3370. S:473, "Straits Settlements."
[54] *S.S.A.M.R.* 1926. p.112.
[55] Ibid. 1928. p. 142

With regards to sanitation, one of the more outstanding legacies of the campaign was the introduction of the "bore-holed latrine" in the last few quarters of the campaign. Known also as the "tube-latrine", this model was considered a more sophisticated version of the pit latrine whose shallow depth and porous walls were significantly prone to leakage. Another common practice, the bucket system, with its poor storage and constant movement, was also vulnerable to spillage of faeces.[56] In proposing his alternative, Russell boasted: "now that we have the bore hole latrine, it is hoped that enthusiasm in overestimating the value of the bucket latrine will not result in the installation of buckets in so many outlying places where they are almost as good as none."[57]

District Health Centres

A more concrete area of the IHB driven campaigns was the setting up of the District Health Unit/Centre. The centres were meant to form the "smallest substantial unit of government," which, to the IHB, was an ideal unit for health work.[58] The unit was meant not only to provide the Malay agricultural heartland with access to modern biomedical facilities, but also to extend preventive health work in the areas concerned. As described by the *Malaccan Observer*:

The District Health Unit is an organisation designed to enable the government to carry on the practice of preventive medicine in the rural areas, in kampong and villages. The term preventive medicine includes more than external sanitation. It involves not only the establishment of latrines, the control of insects and animals, but also such activities such as the mass treatment of ankylostomiasis, malaria, yaws, venereal diseases; the preventive vaccination and inoculations as against smallpox; sanitary surveys with sketch-maps to scale; instant and maternal welfare with instructions to midwives, establishment of baby clinics, etc; a persistent educational campaign of illustrated lectures, posters, house-to-house persuasive conversations, permanent health exhibits; the periodical examination of school children and other; the

[56]W.L. Blakemore, "Bucket Latrines on Hardouin Estate, Provicne Wellesley South" *Malayan Medical Journal.* Vol.1 (1926) pp. 151-54. Clark Yeager. "The Bore-Hole Latrine", *Malaya Medical Journal.* Vol.4, 1929. pp129-132. J.W. Scharff. "The Safe Conversion of Village Refuse and Nightsoil into Valuable Manual", *Journal of the Malayan Branch of the British Medical Association.* 4.1 (June 1940): 128-35.

[57] *S.S.A.M.R.* 1928. p. 149. The bore hole latrine was also extolled by London for being economical and easily introduced to the villages. PRO/CO/825/17/13. "Visit by specialists of the International Rockefeller Foundation Division to study public health conditions in Far East." 17 April 1934.

[58] The ideal rural health unit envisioned by the IHB entailed the stationing of full time medical officials in the administrative districts supervised and supported by central health bodies. Each unit should preferably comprise an area not exceeding a thousand square miles an a population between 15,000-30,000. IHB. *Thirteen Annual Report,* 1926. pp.11-13.

laboratory examination of specimens to detect the preventable disease cases and the healthy carriers of diseases[...][59]

Commencing operations on 1 September 1926, the first District Health Centre was formally opened by the Resident Councillor on 15 December in a ceremony attended by village headmen as well as prominent personalities and their families from Malacca.[60] In total, six District Health Units were opened between September 1926 and December 1927 in the Straits Settlements.[61] The RF officials were pleased with the enthusiastic reception received, especially in the area of maternal and infant health."[62] The units had, in addition, given sanitary and health inspectors a greater presence in the rural districts where they would be able to carry out anti-malaria works and hookworm treatments. In his departing note to his successor Paul Russell, M.E. Barnes underlined the significance of the units as spearheading the development of rural health: "The District Health Unit offers far greater advantages both from the point of the view of rapidity in covering the field, effectiveness in conducting the campaign, and in permanency of results than any other method which has been considered in connection with the Straits Settlements work." (See Table 24 in Appendix 3 of Annex A for details of activities in District Health Centres).[63]

On the conclusion of the campaign, Russell believed the IHB's efforts of expanding the rural health nfrastructure had given a stimulus to the colonial medical services. He

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[59] The *Malaccan Observer.* 20 December 1926.

[60] Each District Health Unit consisted of the following staff: one part time District Health Officer (Asian Assistant Surgeon), one full time District Health Dresser (male nurse-a vaccinator and dispenser), one full time District Health Nurse (Asian female qualified midwife and nurse), one or more District Sanitary Inspector, one part time District Health Microscopist and one full time caretaker. *S.S.A.M.R.* 1928. p. 113-114

[61] The District Health Units in Malacca were: Jasin and Alor Gajah, opened in 26 September 1926 and 6 December 1927 respectively, in Singapore: Paya Lebar and Joo Chiat Road established on 2 May 1927 and 11 June 1927, in Penang: the Tanjong Tokong and Butterworth, Province Wellesley set up on 1 and 27 August 1927. Ibid.1928. "Appendix N: Straits Settlements Rural Sanitation Survey and Campaign, Final Report and Tables, 1925-1928. p.157. Russell was generally pleased with the response of the District Health Units, claiming "kampong people in Penang are flocking to the various clinics at this centre, sometimes more than a hundred at a time, although it has only been function for a short term." RAC: B.210.R.G.5.3. S.1.2.F.2594. C.473H. "The 7th Quarterly Report of the Straits Settlements Rural Sanitation Campaign (third quarter 1927)". 1 October 1927.

[62] RAC.B.210.R.G.5.S.3. F.2594..C.473H. *Second Annual Report of the Straits Settlements Rural Sanitation Campaign, 1927.* p.28.

[63]RAC.B.267.R.G.5.S.1.2. F.3372. "M.E. Barnes to Paul Russell." 5. July 1926.

credited the government for expanding its biomedical infrastructure, including that of anti malaria drainage, social hygiene programmes, and the addition of two new rural hospitals in Malacca. [64] Nonetheless, to the IHB, this emphasis on infrastructure was secondary to what it saw as the most important priority of changing public mindsets.

Public Health Education

Like the anti-hookworm treatments, the promotion of latrines and the setting up of District Health Centres were also part of the campaign's public health education. Unprecedented in both practice and scale, this move was aimed at internalising the culture of modern health and medicine into the public mindset. In this respect, the RF not only made donations to the King Edward VII Medical College in Singapore, with the expectation that preventive health subjects would be included into the curriculum. It also offered fellowships to the leading medical officers in the colony to the United States as well as scholarships in the RF sponsored nursing institution in Manila.[65] The desire to change what was considered unscientific cultures of a backward general public became the primary focus of the IHB's attention.[66] As Russell reported:

> Although from time to time efforts have been made in the Colony to acquaint the people with methods of conserving health, such efforts have not been systematic and sustained. With large populations of varied people who are unfamiliar with Western ideas of medicine and to a large extent are disbelievers, all health work labours under a heavy handicap. Many of the desired reforms require the changing of customs which have been followed by Eastern peoples for centuries. Needless to say, such habits will not be abandoned until the peoples are convinced that the new ways recommended are better than the old. Health education, therefore, appears to be absolutely essential to an adequate public health programme.[67]

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[64] *S.S.A.M.R.* 1928. p.147.

[65] In his fieldtrip to British Malaya in 1915, Victor Heiser concluded the greatest drawback of the colonial medical services was the absence in facilities for an adequate preliminary medical education, even for training junior hospital assistants, pharmacists and nurses. However, he identified the greater obstacle in : "the fact that the men in charge of medical education are apparently well satisfied with present conditions and are not making any determined effort to increase the budget of medical education." Heiser recommended "much good could be accomplished" by providing scholarship in medicine and nursing in The Philippines and America. RAC.B.210.R.G.5.3.F.2595.C.473A. Victor Heiser. "Memorandum on Medical Education in Malaya" July 8, 1915.

[66] In his final report on the campaign, Russell summed up the characteristics of Malayan colonial society where the Malays were shy by nature, showed little interest in Western medicine. In the kampongs areas, he found nearly all Malays to prefer walking barefoot, rendering them vulnerable to hookworm infection. Similarly, the Tamil Coolie was disinclined to wear shoes and was thought to be badly nourished by a mixture of poor diets and high toddy consumption. Even as the Chinese were considered better nourished, he observed most of them were living in crowded residences and almost all went around barefooted. *S.S.A.M.R.*1928. pp. 129-130.

[67]Ibid. p. 131.

Like his colleagues, Russell found in the hookworm an excellent text for public education with "considerable propaganda value", for: "It is so common, so simple to explain, so easily cured and above all, so completely preventable that even the most illiterate coolie can understand it and thus obtains his first idea of Preventive Medicine."[68]

In its campaign, the Board deployed existing and new modes of media to communicate the public health messages across. During anti hookworm treatment sessions, villagers were simultaneously given lectures on latrine construction and excreta disposal, and were also encouraged to wear shoes to reduce the possibilities of hookworm infection. Aside from using different language mediums, lectures were often conducted after working hours, "at places off the beaten track, or to perhaps only a single family or individual."[69] Table 25 (in Appendix 3 of Annex A) reflects the scale of reach of the public lectures given during the campaign in the various lectures.

A substantial portion of the campaign was targeted at children. Simplified materials on public health were distributed to schools with the intention of educating pupils and possibly to their parents about modern healthcare. With regard to the latter, the IHB made use of posters and charts with more direct explanations. Aside from the materials used in previous campaigns in the United States and China, the Board had also commissioned local artists to prepare similar posters. The more outstanding posters drawn during school contests organised by the campaigns were also used for public health education purposes.[70]

The Board also made use of existing annual public exhibitions like the Malacca Agri-Horticultural shows to mount public health displays. Widely attended by the rural population, the exhibitions and especially the demonstrations of the microscopes were popularly received.[71] A more memorable part of the campaign was however the introduction of the film shows to capture local public attention. Described as the "lantern shows", the era of the moving image was introduced by the IHB to the rural heartlands. Among the most frequently screened programme was a local adaptation of

[68] Ibid.
[69] Ibid.
[70] Ibid. p. 132.
[71] Ibid.

"Unhooking the Hookworm", whereby scenes of British Malaya were inserted into the film to provide local references.[72] Overall, the Rockefeller Officials were pleased with the results as shown in Heiser's observations on the enthusiasm displayed where:

> After hearing one of [Dr Russell's] talks on hookworm infection, a coolie almost killed two Tamils who had violated some of the regulations he laid down. Another Malay convert was inspired by his teachings to build a latrine of which he was so proud that he fastened the door with a padlock lest anybody defile it.[73]

Although it was instrumental in initiating these public health education programmes, the IHB did not act alone in delivering the messages it wanted. Rather, it had relied heavily on both the state apparatus as well as civil society participation. Apart from the District Health Centres, the various lectures and educational materials were delivered to schools, government medical institutions as well travelling dispensaries. The publicity efforts were also given a boost by engaging prominent local organisations and community leaders. In the school poster contests in Penang, the local members of the Straits Settlements Legislative Council were invited as judges, and the Governor's wife to grace the events. The largest public relations coup was however scored with the local community merchant leader, Tan Kah Kee. With the assistance of the Secretary of the Chinese Affairs, the IHB secured the commitment of Tan, also the leading shoe manufacturer in the colony, to produce special rubber-soled shoes at low prices.[74] As a token gesture, the tycoon offered 2,000 pairs of these shoes for the campaign for free distribution to schoolchildren through the Education Department. Other than the material benefits, the offer attracted significant publicity, and to Russell, it aided in promoting the message of "Better shoes than Shrouds."[75]

"One of the hardest abnegations"

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[72] Ibid. According to Russell, the campaign staff faced substantial difficulties in operating the film shows in the rural areas. Outside the municipalities, public halls and cinemas, electrical supply was lacking. The glare of the equatorial sun had also prevented the films from being properly screened in the open during the day. Although Russell managed to purchase a portable battery, he found the "translux Daylight" screens deteriorating rapidly in Malaya even when they were "specially prepared for tropical use." *Second Report of the Straits Settlements Sanitation Campaign. 1927.* p. 9.

[73] Victor Heiser. *A Doctor's Odyssey. Adventures in Forty Five Countries* (London: Jonathan Cape, 1936) p. 310.

[74] RAC.B.210.R.G.5. S.3. F.2593.C.473. *Second Annual Report of the Straits Settlements Rural Sanitation Campaign, 1927.* pp. 10-11.

[75] Ibid. p.133.

Besides raising greater public awareness on health and diseases, the sanitation campaign had also generated significant publicity of the RF presence in the colony, in spite of the foundation's desire to keep an almost invisible profile. Writing in his journal, Heiser recalled: "One of the hardest abnegations was entailed by our stipulation that the local health organisation should receive credit for whatever success might be accomplished. As a rule our men were never heard of in the outside world." [76] Nonetheless, the foundation and its staff could not escape the public limelight showered upon them.

Among the most prominent supporters of the IHB activities were the colonial newspapers where several dailies openly advertised its programmes and generously rained praise on the foundation's philanthropic enterprise. In stressing that the RF deserved more than a "passing mention", the *Malayan Tribune* listed the Board's achievements in disease eradication and establishing public health infrastructure around the world. Concerning the local context, the paper added: "And, in particular to the local campaign against hookworm, a disease which if not a vital danger to the human subject, is responsible for much of the ill health and low physical capacity of the Malay race."[77] With similar reference to the rural Malays, the *Straits Echo* poured scorn in the seemingly unhygienic habits of the population whereby "no place [in the rural heartland] was considered clean" and practically every Malay boy has at least a few worms and some die each year because they have a large number of these parasites." Agreeing with the campaign goals, the editor commented: "It is highly important that children should learn habits of health by actual practice. Once a school child has assimilated an idea it will usually influence him through adult life."[78] Supporting the campaign as early as 1924 was the *Penang Gazette* saw a deeper significance of the IHB's programme:

> For if agriculture is to be encouraged in Malays, risks to worms must be eliminated[...]When we consider 23,000 hookworm cases under treatment in Malacca we are not surprise that Malays should be disinclined to work in the fields. [The Malays were not naturally lazy, but] The energies of the race has been sapped by hookworm, malaria and other wasting but preventable diseases and when these have been

[76] Victor Heiser. *A Doctor's Odyssey: Adventures in Forty Five Countries.* p. 290
[77] *The M.T.* 6 August 1927.
[78] *S. E.* 26 October 1927.

eliminated by the aid of modern science, the Malay will be a virile active and happy worker and his country will become agriculturally rich beyond imagination.[79]

Concurring with the IHB's ideals of disease as the cause of poverty, the *Singapore Free Press* magnified the larger political implication of this civilising mission which would relieve the "White man's burdens" over the colonial subjects:

When the rising generations of this country, of all races and communities, have been freed from the curse of intestinal parasitism and from the ravages of malaria, future historians may find no causes to deplore their slackness, their lack of physical and moral stamina, and a citizenship may be built up which will not only desire to but be able to undertake its own governance. [80]

To some degree, the activities of the IHB in Malaya helped reduced the anti-American sentiment in the territory over the increasing pressures of American competition in the rubber industry.[81] At this point, it is also crucial to note the extent in which the anti-hookworm programme was elevated by local colonial society through the media to reinforce not just its pre-existing racial prejudice for the "lazy native." By claiming of a solution to this "ill", it also presupposed Western led scientific superiority in enlightening the ignorant colonial subjects.

Manderson is of the opinion that the Rockefeller project in Malaya was shortlived: "Without continued external funding, the programme lost its priority: The government was not prepared to commit substantial recurrent expenditure to undertake soil sanitation and to maintain and erect more latrines, and instead, it turned backed to other public health issues."[82] The reduction in the intensity of rural sanitation and anti-hookworm campaigns should not be construed as a loss in momentum. By the end of the sanitation campaign in 1928, the Straits Settlements had internalised the bulk of the practices promoted in the campaign. Ankylostomiasis became elevated to the primary statistics of infectious diseases in the colony and rural health services were being expanded. In the meantime, public health officials began to conduct medical inspections and examinations on schoolchildren with greater frequency. There was, in addition, a

[79] *P.G.*, 27 April 1927.
[80] *S.F.P.* 14 June 1927.
[81] For details of American presence in British Malaya, see: Jim Baker. *The Eagle in the Lion City* (Singapore: Landmark Books, 2005).
[82] Manderson. "Race, Colonial Mentality and Public Health", in Rimmer and Allen (eds). *The Underside of Malaysian History*. p. 210.

heightened emphasis on public health education where displays, film shows, exhibitions and lectures were carried out throughout the colony long after the IHB officials had departed.[83]

Conclusion: The "Good Samaritan"

H.R Luce defined America's place on the world stage as "the dynamic leader of world trade, the key guarantor of the freedom of the seas, the disseminator of scientific leadership and the 'Good Samaritan' for the entire world."[84] Like its cultural exports, economic and military dominance, debates have been raised on the degree of altruism of American charity and in particular, RF's philanthropic enterprise. As reflected in this chapter, the IHB had pioneered not just the extension of rural health and medical infrastructure into the kampongs of Malaya. More crucially, it provided a new definition and impetus towards the development of public health education as a means of spreading the ideas of modern biomedicine. In the process, the Board sought to mobilise the resources of local colonial civil society by engaging prominent public personalities and groups in their campaigns. In its views, such contributions were:

> [...]the province of the voluntary agency: it can and should keep ahead of official health practice in each locality, advancing steadily to newer fields as each of its demonstrations prove successful and the constituted authorities are ready to take full responsibility for the activity. The International Health Board has been conducted on such principles and it does not feel that any demonstration has been successful unless its assistance ceases to be needed within a reasonable time. Any project which is not absorbed into the official health service is obviously unsuited to the time or the place.[85]

Overall, the Foundation's representatives were keen to downplay their presence, seeking to act as a low profile partner instead of a prominent patron.[86] As the IHB emphasized: "No private and temporary agency, whatever its resources, could or should discharge

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[83] Although the campaign was considered a success in the Straits Settlements, similar undertakings by the IHB were not replicated in the rest of the Malay States subsequently. Records from the RAC and the Colonial Office did not indicate the reasons. Victor Heiser merely recollected in his journal: "Owing to its tremendous wealth, the government of the Federated Malay States did not feel in need of our financial assistance." Heiser. *A Doctor's Odyssey*. p. 311. The discontinuity however could be speculated to several attributes, ranging from the disinclination of the medical officers of the Malay States to embark on such campaigns to the reluctance of the IHB to undertake programmes in places where government medical services were yet to be satisfactory established.

[84] David Slater. *Geopolitics and the Post-Colonial: Rethinking North-South Relations*. p. 52. See also: H.R. Luce. *The American Century* (New York and Toronto: Farrar & Rinehart, 1941).

[85] RAC. IHB. *Tenth Annual Report*. 1923. p. 2.

[86] Ibid. *Thirteen Annual Report*. 1926. p. 14

responsibilities which by their nature, belong to the constituted authorities of the commonwealth. Private enterprise therefore, may be best employed in awakening public opinion and thereby encouraging state and county officials to establish permanent agencies for health work."[87] Hence, IHB officials in Malaya were keen to politically de-odorise their works in order to reduce any forms of paternalism or cultural dependence.

The activities of the IHB were eventually absorbed by the colonial health services, whereby both hookworm diseases and accompanying it, rural healthcare were given heightened priorities. This in some ways, also signified the increased penetration of Western based modern biomedicine into the colonial subjects through a combination of more stringent sanitary regulations as well as public health education. Even if the experiences of the individual IHB representatives were not thoroughly pleasant in their interactions with local society, their contributions were subsequently given substantial acknowledgements.

However widespread the projection of their philanthropic enterprise, the RF was not the only organisation with an international reach in British Malaya. Chapters 6 and 7 will reveal the localisation of global health movements in colonial civil society by the predominantly transnational Chinese based anti-opium societies as well as the medical missions and social hygiene activities headed predominately by European women. Before proceeding to the highly contentious health politics of these groups, the next chapter will feature the role of health lobbies during the Spanish Influenza of 1918; a pandemic which swept through the towns, plantations and villages in Malaya and the world.

[87] Ibid. *Tenth Annual Report*, 1922, p. 6.

Chapter 5
"Rising finely to the Occasion": Colonial Civil Society during the Spanish Influenza

The influenza epidemic swept through out midst in September and October, unhappily with fatal consequences to a number of friends in the Tamil community. We are glad to say that though terribly severe while it lasted, its duration was mercifully short. On the other hand, the great news that the armistice has been signed filled us with unaccustomed joy.

Notes from Negri Sembilan to *the Singapore Diocesan Magazine* in 1918.[1]

I work in a mine close by and a few days ago, I was laid down with influenza. One day, I was very ill. I had told my prayers because I thought I was going to die, and was lying down. Then my *mater* (police) came along and together with several others who were ill, I was taken to a certain place...where I found hundred of others as bad as ourselves. Some were dying and I felt that my end too had come. There a clerk came alongside my bed and gave me some neat brandy, which I relished very much. While all the other people around me were sleeping, I was awaken and saw my native land, The Himalayas, and the burning Ganges, and many other things, suddenly I became stiff and know no more. I opened my eyes. The place was pitched dark and I heard birds singing outside and cocks crowing far away. I was in the room of the dead, awaiting burial, the clerk thought that I was dead and had taken me to the mortuary.

An account of a Tamil victim of the influenza translated by the *Times of Malaya* under the title "Dead men stories"[2]

Introduction: "Dead Men Stories"

From February to May of 2003, the SARS (Severe Acute Respiratory Syndrome) pandemic took about 1,000 lives across the world with the more serious epicentres in China, Hong Kong, Taiwan and Singapore. Even as the mortality rates were comparatively minimal by historical standards, significant scrutiny was placed on governments in managing the outbreak. With infected hospitals, panicked populations, emptied streets, threatened reputations and economies, SARS became a public health emergency. In trying to contain the further spread of the epidemic, governments hastily resurrected antiquated quarantine legislations, increased surveillance on the movement of people, intensified the cleaning of streets and public health education campaigns.[3] Even as collective involvement in preventing SARS was urged, like its predecessors, the 21st century state has been portrayed as the paramount player in shepherding a helpless society away from an apparently uncontrollable scourge.

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[1] *Singapore Diocese Magazine* (Henceforth known as :*S. D.M.*) Feb 1919. 9(34). pp.35-6.
[2] *T.M.*, 7 November 1918.
[3] World Health Organisation. SARS: *How a Global Epidemic was Stopped* (Gevena: World Health Organisation. 2006).

The case of the Spanish Influenza pandemic in Malaya almost a century ago presented a different scenario from the supposed passivity of civil society as well as the primacy of the state. In spite of a death toll of about 60,000 within a period of two months (as compared to only 33 people in Singapore during SARS), the episode remains largely forgotten.[4] Overseeing extensive territories with a fledging public health infrastructure, the ability of the colonial administration to tackle a public health emergency was stunted. As government medical facilities were overwhelmed with the sudden influx of casualties, the rest of society was generally left to its own devices. This was where various organisations and groups stepped in to fill the vacuum left by the colonial medical services in mitigating the suffering of the affected. Aside from exposing the limitations of the colonial state apparatus, the epidemic also tested the pace of reaction of community elements in handling the crisis. This included the control and dissemination of information relating to the pandemic as well as mobilising and channelling resources for relief work.

Whereas the previous discussions have been placed along geographically confined categories of urban, rural and estate health, this chapter contextualises the role of health lobbies along a broader "Malayan" level. It highlights readiness of the colonial medical services in responding to a public health emergency. The measures of the authorities are in turn juxtaposed against that of the colonial civil society. In this chapter, the newspaper agencies will be prominently featured here as their roles in monitoring the transmission patterns of the pandemic, reporting on mortality rates, fundraising and propagating public health literature. Another group of players to be featured here were community and business groups banded together to establish makeshift relief measures. The level of involvement, ranged from individual commitment to the participation of entire community organisations. Last, but not least to be discussed is the role of the medical market which witnessed heightened activity when government prescriptions were either unavailable or thought to be unconvincing.

[4] For the politics of historicisation of SARS in Singapore, see: Liew Kai Khiun. "A Defining Moment. Defining a Moment: Making SARS History in Singapore", in Brenda Yeoh and Rachel Safman (eds) *A Comparative History of Public Health in Asia-Pacific* (Singapore: World Scientific: Forthcoming).

1918 in Malaya

Compared to other diseases, the historiography of the 1918 influenza has been a recent field arising from the concern of a forgotten pandemic that took about thirty million lives worldwide. Its aetiological and epidemiological characteristics offered crucial insights to the undercurrent of socio-economic patterns pertaining to environmental conditions demographical changes and socio-political arrangements.[5] Although taking about one to five percent of the total population in each country, the episode was quickly forgotten as the pandemic left as quickly as it came.[6] Similar trends can also be found in the case of British Malaya where writings on the influenza have been overshadowed by endemic diseases like malaria and tuberculosis.[7] As discussed in Chapter One, the colonial authorities were not unfamiliar to the visitations of epidemics particularly that of plague, smallpox and cholera even if these outbreaks were largely localised. There were years epidemics of a broader level were felt, such as the malaria epidemics in 1901 and 1911 where hospital admissions and death rates from the vector infection were comparatively higher. However, unlike the short burst of influenza lasting for one to two months, the mortality rates arising from these epidemics were spread over the entire year. Hence, being a familiar disease, malaria did not constitute as a health emergency. Although the colonial medical services did monitor the incidences of influenza in Malaya, its enormity was significantly underrated and was not included in the list of notifable disease until 1919.

The influenza pandemic struck British Malaya in two successive waves, between June and October of 1918. The first official warning of the second (and more deadly) wave came from a telegram from the Governor General of South Africa to Singapore on 12 October 1918. Read in full before the Federal Council of the Federated Malay States it stated:

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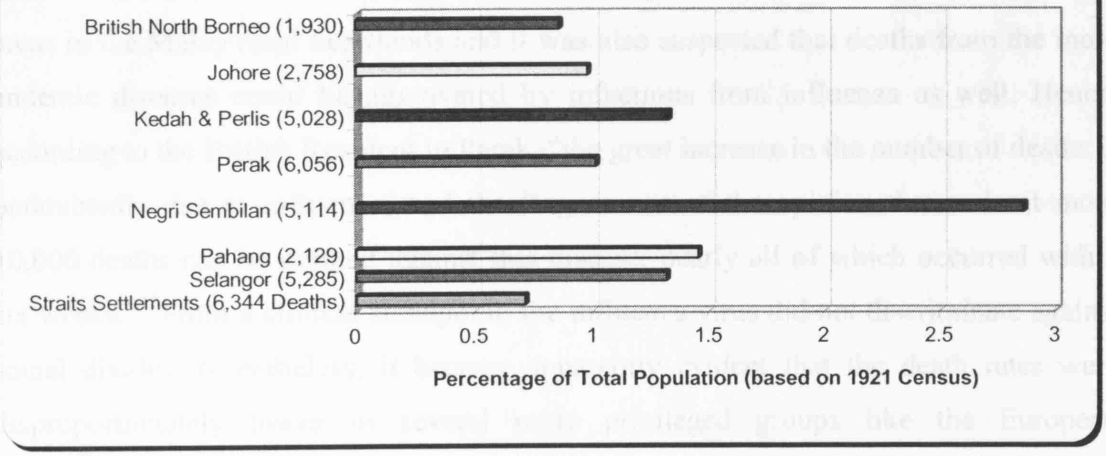
[5] See: Howard Phillips & David Killingray(eds). *The Spanish Influenza Pandemic of 1918-1919: New Perspectives* (London: Routledge: 2003).
[6] Ibid. pp. 11-12.
[7] Manderson has only given a passing reference to the episode of the influenza pandemic in Malaya. See: Manderson. *Sickness and the State*. pp.51-53.

In view of the terrible experience through which South Africa is passing as a result of the violent outbreak of so-called Spanish fever with highly pneumonic characteristics, the Prime Minister of the Union of South Africa considers it advisable to draw your special attention to the extreme seriousness of the malady with a view to the possibility of timely measures being taken by your government to prevent its introduction from overseas. This malady is infectious in the highest degree and produces extreme prostration with an appalling death rate among coloured persons and natives while among Europeans after a week's experience, there is, now distinctly increased seriousness in the character of attack. At Kimberly yesterday, 50 Europeans died. At Cape Town, a large number of coloured persons and natives are dying daily in hundreds. The Prime Minister is anxious that your country be spared similar calamity and has accordingly taken this step to give your timely warning. [8]

As with the rest of the world, the exact numbers fallen to the pandemic in British Malaya may never be known. The general report by the British Ministry of Health suggested the region was only lightly affected. Even as it recognised the disease was apparently widespread, from the death rates of 36,294 in the Straits Settlements, "only 3,500 were ascribed to influenza."[9] However, the final toll tabulated in Chart 16 below from the annual reports of the various states in British Malaya puts the figure at around 35,000.

Chart 16: Deaths from Influenza and Percentage of Total Population



Source: Note: The figures were derived from the difference between the mortality rates of 1918 and that of a more stable year in 1917 and measured against the population of Malaya based on the *Census of British Malaya*, 1921.

[8] *Federated Malay States. Legislative Council Proceedings*. 13 October 1918.
[9] Ministry of Health (United Kingdom). *Report on the Pandemic of Influenza*, 1918-1919. p. 386.

From the data above, it seems that close to one per cent of the population of British Malaya perished during the influenza pandemic, distorting population figures significantly. As reported from a census in 1921: "it is probably that the number of deaths due to influenza was not less than 40,000 or approximately 1 in 80 of the population."[10] The report however played down the severity when: "Heavy as this death roll was, it cannot compare even proportionately with that of British India, where it is estimated that 7,000,000 deaths were directly attributed to the disease or 1 in 35 of the total population."[11]

Chart 16 also revealed the extent of the impact of the pandemic in the different colonial entities in Malaya. The more congested urban areas of the Straits Settlements however suffered proportionately less casualties from the hinterland. It is interesting to note that, in spite of being the most densely populated settlement in the region, Singapore was spared the calamity of the epidemic that had ravaged the neighbouring territories.[12] Of all states, Negri Sembilan bore the highest mortality rate with almost three percent of deaths attributed to the influenza. The other Malay States were also not spared with a less extreme percentage of about 1.4 percent. Overall, the mortality figure was regarded as a conservative estimate.

The colonial medical services were unable to tally the count of the more inaccessible areas in the Malay rural heartlands and it was also suspected that deaths from the more endemic diseases could be aggravated by infections from influenza as well. Hence, according to the British Resident in Perak, "the great increase in the number of deaths is undoubtedly due to influenza, and the Registrar is of the opinion that at least more 10,000 deaths can be debited against this disease, nearly all of which occurred within six weeks."[13]From a clinical standpoint, the influenza virus did not discriminate against social divides. Nonetheless, it became apparently evident that the death rates were disproportionately lower in several more privileged groups like the European communities. Conversely, other groups like the ethnic Indian migrant population seemed to be the worst affected.[14]

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[10] *The Census of British Malaya, 1921*. p. 20.
[11] Ibid.
[12] *S.T.* 2 November 1918.
[13] *Annual Report for the State of Perak, 1918*. p. 17
[14] See: Liew Kai Khiun. "Terribly Severe yet Mercifully Short", in *Modern Asian Studies*: forthcoming

The actual collection of data, particularly on health statistics, remained difficult on several grounds. With the exceptions of the larger plantations and urban centres, such institutions remained largely inaccessible to the local population, especially those from the rural and poorer sections. Furthermore, as medically trained officers remained scarce, the task of determining the cause of death rested in the hands of the police constables who were fare less competent in categorising the myriad causes of mortality. Hence, it was not surprising that in his report on the section of 1918 influenza in Singapore, the League of Nations official, Norman White, stated that the "death rates[...]are obviously of little value" in estimating the extent of actual mortality figures.[15]

Like most of its counterparts around the world, the public health regime in British Malaya was taken by surprise by the influenza pandemic of 1918. Similar to the experiences of governments in most pandemics, the authorities were neither able to detect the advancing influenza nor possess a clear grasp of the casualties incurred. Reporting on the St John's Island Quarantine Centre in Singapore in 1918, the Port Health Officer claimed awareness and control of the situation. Alleging that influenza arrived by ships from other Asian ports, he stated that the situation was brought under control by the detention of deck passengers from four Dutch vessels for two weeks in October, which, "I think is instrumental in excluding a large amount of the disease.[16] The case of influenza however was only a more visible case of a structural deficiency within the colonial medical services in obtaining more accurate and complete epidemiological data on diseases. As indicated by Manderson, a "lack of a clear picture on the prevalence of particular diseases made the development of intervention strategies difficult."[17] Without such advantages, the authorities were left on the defensive.

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[15] Norman F. White. *The Prevalence of Epidemic Disease and Port Health Organisations and Procedures in the Far East.* Report presented to the Health Committee of the League of Nations. Geneva, 1923. p. 49.-(National University of Singapore, Central Library)
[16] *S.S.M.R.* 1918. pp.88-9.
[17] Manderson. *Sickness & the State.* p. 60.

Crippling the State

The response of the colonial government can in turn be gauged on several levels, namely that of identification of epidemiological patterns, implementation of preventive measures, and provision of relief and welfare for the victims. Attempts were made at the institutional level to decipher the aetiology of the influenza epidemic. While the initial suspicion of plague was cleared, the Kuala Lumpur based Institute for Medical Research admitted it was "far from possessing the exact knowledge" of the cause and prevention of the epidemic.[18] This followed the failure by the institute to develop a preventive vaccine prepared from organisms isolated from the respiratory secretions.[19] Nonetheless, they were keen to be involved in larger preventive measures. These medical authorities were well represented in a meeting of government officials and community leaders to discuss on measures to contain the epidemic on 21 October 1918 in the Federal capital of Kuala Lumpur.

During the meeting, Dr, McGregor from the Medical Research Department called for the avoidance of crowded places and plantation managers to prohibit coolies from moving between estates. Supporting his views was Dr Macintyre who felt that the overcrowded living conditions among the poorer sections of Kuala Lumpur were a possible breeding ground for the influenza. Underlining the confusion of the diseases, a Chinese community participant, Mr. Choo Kia Peng observed the majority of Asians seemed to have thought that the influenza was merely another outbreak of malarial fever and had not taken any precautions against the infection. He suggested more official circulars to be distributed to the public about the nature of the epidemic.

Reported across the other newspapers in British Malaya,[20] it was likely that the measures discussed in the meeting became a template for municipal authorities and public health officials across the territory for containing the influenza.[21] Nevertheless, in hindsight, the government found these measures to be generally limited and even counterproductive. As admitted by Annual Report of the Federated Malay States: "The layman is bewildered by this multiplicity of the recommendations received from different quarters, often contradictory, and, although various committees have met to

[18] Institute for Medical Research. *The Institute for Medical Research*, 1900-1950.p. 57.
[19] Ibid.
[20] *S.E.* 25 October 1918.
[21] *S.S.L.C.P. Report from the Singapore Municipal Health Office for the year 1918.* pp.2-4.

consider the best means of combating another similar epidemic, it has not been possible to achieve anything with approved unanimity."[22]

On their own accord, health authorities took rudimentary sanitary and hygiene measures to contain the epidemic. The Municipal Health Department in Penang carried out house-to-house inspections for influenza cases, including the European community even though they were deemed less susceptible to the virus. Disinfectants were also liberally distributed and public places cleaned more frequently. Schools, cinemas and other amusement centres were closed to prevent the further spread of the influenza during the month of October.[23] In Selangor, the earliest official response came in a medical circular urging those who were unwell to stay in bed until the symptoms of influenza subsided. Disinfection by boiling all linen especially pillow-cases, handkerchiefs and sheets, as well as plenty of good food and open fresh air, was also recommended. In addition, the circular called on those infected to take specifically five grains of "Dover powder" and aspirins to be taken three times a day as a curative measure.[24] It was not clear whether the targeted population dutifully received these public health messages. According to the *Pinang Gazette:*

> We regret to learn that the epidemic is spreading and whole families are being attacked. This is hardly to be wondered at, as we are told[...]that ninety per cent of the Chinese wilfully neglect to follow the instructions of the health department, particularly in the matters of segregation and observance of hygiene rules. The Indian patients, we believed, are far more tractable and a larger percentage of recoveries are reported where proper medical treatment is given to them.[25]

Similarly, the government medical officer reported from the island of Labuan of the futility of convincing the local Kadayan groups, already known to be suspicious of Western medicine, about the severity of the influenza.[26]

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[22] *F.M.S.A.R.* 1918. p. 19.
[23] *S.E.* 21 October 1918.
[24] *S.F.P.* 17 October 1918.
[25] *P.G.* 25 October 1918.
[26] *S.S.M.R.*. 1918. p. 193.

The authorities in Singapore watered the streets with greater frequency and disseminated information about the influenza in both English and the other vernacular languages in the newspapers. They also attempted to isolate infected persons in one building to prevent them from spreading the virus.[27] The vacant wards at the Moulmein Road hospital were suggested to house the increasing number of patients, but this could not be utilised due to the shortage of staff.[28] As experienced in the rest of British Malaya, it was these difficulties that crippled the healthcare system in the colony during the concluding months of 1918.

Gardeners to Dressers: Ovecrowding in Hospitals

Almost all hospitals and dispensaries in the colony were put under tremendous strain, even as it was possible that the figures were just a fraction of the total cases infected. Although the epidemic was milder than the rest of the peninsula, its effects were equally visible in Singapore. The Tan Tock Seng hospital registered 570 cases in the first week of November with 210 cases of mortality.[29] The Kerbang Kerbau maternity hospital treated 33 cases of influenza and had four deaths in its ward at the same time.[30] The hospital also saw itself issuing about 500 medical certificates to civil servants who were down with influenza.[31] About 3,308 cases of influenza in Selangor were treated in the hospitals, of which 523 could not be saved.[32] The presence of the influenza was also detected in the Quarantine Centre at Port Swettenham, one of the main screening centres for migrant labour. Although the number of immigrants passing through the camp dropped to 32,696 from 48,434, in 1917, about 107 influenza related deaths were reported.[33]

Total admissions to the hospitals amounted to 26,963 as compared to 18,344 in 1917 in Negri Sembilan. About 17,201 of them were in-patients compared to 13,403 in 1917. About 2,739 of the inpatients died in hospital, recording a death rate of 15.34 percent of the total admissions. 836 deaths occurred within 48 hours of admissions. Outpatient

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[27] *S.T.* 26 October 1918.
[28] *S.S.L.C.P .Report of the Municipal Health Office, Singapore, for the year 1918.* p.3.
[29] *S.S.A.M.R.* 1918. p. 440.
[30] Ibid.
[31] Ibid.
[32] *Annual Report for the State of Selangor.*1918.p. 13.
[33] Ibid. p. 13

rates increased to 43,046 against 40,754, an increase of 2,292. [34] In Perak, about 5,144 cases were referred to the hospitals with another 8,273 as outpatients during the influenza epidemic. Of this figure, 917 died in their wards. But, the medical report warned that these figures were just the tip of the iceberg for many were treated in the estate hospitals while many more, especially the Malays, preferred to remain in their houses.[35] In Kedah, *The Straits Echo* reported that at one hospital, the entire staff fell ill to the virus. Other key European medical authorities in the state were also sickened by the influenza to administer their duties adequately.[36] In fact, admitting its desperate condition, the colonial officials in the state of Pahang reported that its hospitals became so overcrowded that patients were turned away, and sanitary work around the vicinities were neglected as even gardeners and casual workers (burial coolies) were pressed into service as attendants.[37] It was only the Sungei Bakap Hospital in Province Wellesley that managed actually to send a Malay dresser to the villages to distribute the relevant drugs and disinfectants.[38] Caught off guard with a depleted staff and scattered bureaucratic structure, the public health infrastructure was paralysed by the pandemic, and could no longer shield its subjects, a majority of whom had to fend for themselves.

"Impressing on the Seriousness of the Situation": Influenza and the Media

In light of the structural inadequacies of states, the rate of response of civil society to a public health emergency becomes crucial. These responses can be discussed along three levels, mainly, the role of the media, community organisations and society at large. While many journalists fell ill to influenza, this did not seemed to have affected the daily editions adversely. The presence of the press was critical to the maintenance of the semblance of normality in the face of severe disruptions of public services and infrastructure caused by the influenza outbreak. In this respect, the colonial media found itself assuming the roles of providing epidemiological and public health information, reporting on, and participating in community relief efforts.[39] Without the articles of the

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[34] *Annual Report of the State of Negri Sembilan. 1918.* p. 12.
[35] *Annual Report for the State of Perak, 1918.* p. 17
[36] *S.E.* 19 October 1918.
[37] *Annual Report for the State of Pahang.* p. 20.
[38] *S.S.M.R.* 1918. p. 57.
[39] The role of the media during major epidemics has also been given significant acknowledgement only recently as seen in Sivaramakrishnan's study of the involvement of the local newspapers and journals during the plague epidemic in Colonial Punjab in the 1890s. Sivaramakrishnan. *Old Potions, New Bottles.* pp. 53-86.

colonial newspapers placing the influenza pandemic in the public limelight, it would have remained another entry of diseases in a "bad year" in official annual reports.[40]

In contrast to the only public alert of the influenza from Pretoria, early detection by the state was not evident. On the contrary, the newspapers had eyed the impending arrival of the pandemic with consistent reports of severe outbreaks from the region since August.[41] In fact, as early as July 1918, a concerned reader wrote to the Singapore based *Straits Times* about the outbreak of Cerebro Meningitis Fever in the United States and accused the local authorities of endeavouring to keep the matter secret.[42] Another reader complained to the *Singapore Free Press* on the presence of influenza in Perak as early as September, but the authorities only took action on 22 October after the reports on the epidemic appeared repeatedly in the newspapers.[43] Another angry reader wrote to the paper questioning the belated efforts by the medical department to print and disseminate pamphlets about the influenza immediately when it was first reported.[44]

With its correspondents spread across the colony, the press was able to trace the possible transmission routes of influenza as well as in territories where the mortality rates were more severe. As the epidemic had broken out almost simultaneously in both the Malayan Peninsula and British North Borneo at around June and October in 1918, it remains difficult to pinpoint the route of transmission.[45] Commonly believed to have spread from the principal port of Singapore to the rest of the region, the pandemic was nicknamed as the "Singapore Fever" or "Europe Fever".[46] Locals termed the influenza epidemic as "foul wind" coming from evil spirits.[47] The *Malayan Tribune* speculated several routes of transmissions, mainly from Manchuria and Viadivostok via Hong

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[40] In his annual address, Governor Arthur Young gave only a passing reference to the influenza under the part on public health: "I regret to say the second half of the year has brought with it no improvement in this disease, which appears to be worldwide. Incidentally, the epidemic has caused serious dislocation to business and the traffic on some railway lines had to be altogether suspended." High Commissioner of Federated Malay States. Sir Arthur Young to Federal Legislative Council. Federated Malay States *S.S.L.C.P.* 3 December 1918.
[41] *S.F.P.* 12 October 1920.
[42] *S.T.* 8 July 1918
[43] Ibid. 31 October. 1918.
[44] Ibid. 18 October 1918.
[45] For a more detailed account of the possible transmission route of the influenza epidemic within the South China Sea, see: State of North Borneo. *Annual Report 1918*. p. 239.
[46] *S.F.P.* 16 October 1918.
[47] Ibid. The Malays in Kedah termed the influenza as "Demam Khamis" or "Thursday Fever" as many were believed to have been infected on Thursdays. The influenza was also given the same name of plague or "khamis". *P.G.*, 1 November 1918.

Kong, from India and Ceylon, and Spain through The Philippines."[48] All these theories however, have yet to be concretely substantiated.[49]

Nonetheless, even by early October, the media was convinced the influenza "in the East does not assume so serious a character as it does it the West."[50] A week later, it took on a more alarmist tone: "The present epidemic of influenza is one of the worst that has occurred. It has finally broken through hygienic precautions and taken the fullest advantage of the deplorable neglect of the native population of Singapore, Penang and the Federated Malay States."[51] According to the *Pinang Gazette*, "in the memory of the oldest resident in Singapore, there had never been such an extensive epidemic of influenza and dengue fever in the town."

More importantly, the colonial newspapers presented a human face to the suffering and disruptions through accounts of panics, breakdowns in basic services, deaths and funerals. The *Times of Malaya* recorded about 38 deaths in one day in some areas in the state of Perak, while class attendances were drastically reduced in its schools. The influenza had also reportedly affected the public infrastructure network of the state. Train services in the town of Ipoh were suspended without notice as a majority of the rail staff had fallen ill, leaving passengers stranded. As the *Straits Echo* observed, "daily travellers to Batu Gajah, Kampar, Taiping and Kuala Kangsar were put to considerable inconvenience and annoyance by the failure of the Railway Department to observe the most elementary mode of business."[52]

In the Northern Malay states of Kedah and Perlis, the *Straits Times* correspondent was of the opinion that mortality was substantially heavier than the official count which was largely confined to municipal limits. In a thinly veiled critique against the government figures, the paper boasted: "it is only those who had been mixing up with people and moving around plantations and remote kampongs in distant districts who could realised

[48] *M.T.* 26 October 1918.
[49] The first attempts to control its variant manifestation came in the suspension of immigration from China to Malaya came after the news of outbreak in Cerebral Spinal Meningitis fever in Southern China and Hong Kong in 1917.Ibid. 30 March 1918.
[50] *P.G.* 9 October 1918.
[51] Ibid. 18 October 1918.
[52] *S.E.* 23 October 1918.

the misery, despair and pain which (the influenza) had wrought on its people."[53] Similarly, the *Pinang Gazette* reported Kedah was in a grip of influenza as work was in a standstill in many plantations.[54] In an article reflecting on the episode two months after its outbreak, the *Straits Times* recalled that in some districts, people were dying like flies, and some were left on the roadside, having failed to make it to the local hospitals. The village of Permatang for one, was losing ten people a day at the same period, and the mortality in areas like Sungei Penang, Sungei Rusa and Permatang Pasir registered a loss of 300 people. The saddest case featured seemed to be in a hamlet in Kampong Raju whereby only 12 out of 60 people survived the epidemic. In many cases, children were left without basic necessities as the influenza plunged the poor into greater suffering.[55] As the correspondent noted: "It was really pathetic to see member after member of the same family being carried out of the house within a short interval of each other. A Malay in Kuda Prye buried a child one day another the next day, another and was himself buried. In many cases, after burying the mother, the funeral party would return home to take away the child and wife."[56]

Aside from providing updates and stories, the newspapers in British Malaya also took on the task of propagating public health information regarding recommendations to prevent influenza transmission. These came in either publishing government advisories and circulars, or suggestions from readers and journalists. According the *Pinang Gazette*, the clinical symptoms of influenza were:

> Apart from the characteristic catarrh in the throat and nose[...]infective pneumonia is common to about 50 per cent of the cases. Not only has agonising headaches been common, but cerebral symptoms appear to occur in an average of 25 per cent of the cases. These vary from a delirium, causing more or less anxiety, to definite meningitis producing rapid and stupor and ultimately, coma.[57]

This was a view shared by the *Malay Mail* which described the physical manifestations as: "redness of the plate and anterior pillars of throat, pale tongue, enlargement of the glands of neck and armpits and reduction in pulse rates."[58]

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[53] *S.T.* 8 January 1919.
[54] *P.G.* 18 October 1918.
[55] *S.T.* 8 January 1919.
[56] Ibid.
[57] *P.G.* 18 October 1918.
[58] *M.M.* 5 October 1918.

In the initial stages of the outbreak, the *Singapore Free Press* tried to assure the public that influenza usually flourished in places with a wider range of temperature. Nevertheless, it urged readers to avoid crowded places, and that houses should be kept clean.[59] It recommended other preventive measures including the discouragement of promiscuous spitting and sneezing, daily washing of all floors with disinfectants, frequent baths, throat gargling with prophylactic, doors and windows to be kept closed, and beddings, mattresses and mats to be dried daily.[60] *The Malay Mail* advocated iodine treatment, free purgation with calomel and salts, mixture of salicylate of soda, bicarbonate and chloroform water, in addition to the emphasis on personal cleanliness.[61] The *Pinang Gazette* listed seven main precautions against influenza involving the avoidance of crowded public spaces, the airing and drying of mattresses and clothes, restraint from spitting, frequent disinfections of houses and even the limited consumption of quinine once a day.[62]

Another newspaper, *The Times of Malaya* quoted the recommendations of a plantation owner on preventive measures against the influenza in estates. He suggested Listerine to be the more appropriate solution than the conventional iodine wash spraying which was deemed difficult to administer. This should be supplemented with a good tonic of santogen and phoeferine as well. Other recommendations included the complete lime-washing of all buildings, destruction of home incinerators and the mixing of potassium permanganate with water supplies. Even if such measures would increase labour costs, he concluded it to be cheaper than burial expenses.[63]

In reporting on the developments of a public health emergency, the editors did not hesitate to lash out at what they regarded as the inertia of the government. Not only were the newspapers critical of the apparent absence and neglect of public institutions in pre-empting the outbreaks and tending actively to the sick. Several papers questioned their fundamental preparedness in shielding the colony from the visitations of diseases. While recognising the severity of the epidemic and the strain on state resources,

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[59] *S.F.P.* 17 October 1918.
[60] *S.F.P.* 16 October 1918.
[61] *M.M.* 5 October 1918.
[62] *PG*, 18 October 1918.
[63] *T.M.* 31 October 1918.

criticism of the more outstanding limitations were forthcoming. In dramatising the death toll in Perak of ninety victims within two days, The *Times of Malaya* stressed, "we give these figures not of course with the object of scaring the public, but solely for the purpose of impressing upon the authorities the seriousness of the situation."[64] Claiming anonymity, one supposedly socially reputable person stated in the same paper: "Speaking as a layman, I think when you herd together seventy men in a ward intended for only thirty or forty, there is very little chance of anyone of them recovering from any disease...[and] how can you say they are doing their best when the medical officer is always on leave and when staff is reduced and nothing done? "[65]

By the end of October, another reader came up with a more systematic critique of the government's inadequacy in dealing with the influenza. This ranged from the failure to respond to the epidemic until it was reported in the papers, to the general ignorance of the influenza by most government departments. He also lamented the overcrowding of hospitals and added that the roads should have been patrolled so that there would be, "no more cases of deaths by the roadside from those unable to reach the hospitals."[66] The writer called for the government to act against what he considered the insanitary living conditions of the non-European groups who were "deplorably dirty in their habits" as he felt that it is "not funk that kills the poorer classes, but the dirty habits and indifference of those in authority over them."[67]

Regarding the epidemic as a "deadly scourge that was worst than the grim war itself, the *Pinang Gazette* chided the government for serious bureaucratic neglect and inefficiency given the vulnerabilities of the regions to the spread of diseases where:

> To regard ourselves as immune from all the possibilities of a return of the full disease is to harbour the delusion that may have the most dire consequences. What happened some months ago when municipal and government officials had slowly to unwind themselves from the coils of red tape and reluctantly tear themselves away from the congenial occupation of indicting minute papers in excuse of their neglect to make show of human intelligence and active interests in fighting the influenza, may be pardoned. In other

[64] *T.M.* 18 October 1918.
[65] *T.M.* 17 October 1918.
[66] *T.M.* 31 October 1918.
[67] Ibid.

places, there was the same disinclination even to think of doing anything with less of taking action over an unnotifable case.[68]

The concerns over the colonial government's apparent limited response during 1918, continued to reverberate into the subsequent years. The *Straits Times* editorial in 1920 noted:

That we have remained free from serious epidemics must in a very large measure be attributed to the favours of gods, but...we cannot continue to bank on good luck. We must have something more durable. For instance, we have remained free from yellow fever. We believed it was Dr. Malcolm Watson who pointed out that once yellow fever obtained a firm hold on a city like Singapore, there would soon not be sufficient people living to bury the dead.[69]

Overall, the unreserved chorus of media criticisms of the authorities during the influenza epidemic was another vocal demand by colonial civil society for more active involvement from the state. While these dailies did not speculate on cures for influenza, they considered the disease to be preventable through a more vigilant public health machinery. In the meantime, society had to take care of itself.

From Private cars to ambulances: The Involvement of Community Groups

Another salient aspect of the influenza episode was the organisation of relief work by community bodies for influenza victims. The ethnic Chinese groups displayed their mobilisational capacities in terms of the magnitude of their efforts. In trying to fight the epidemic, they managed to institutionalise and coordinate relief efforts within a fortnight. In Penang, an Influenza Relief Fund was rapidly established to assist victims from more financially distressed backgrounds. Many prominent individuals and organisations made generous donations and had their names published in the main newspapers. A similar fund was set up by a Chinese based Lam Huan hospital to help the poor defray medical expenses. Altogether, about $13,000 and $5,000 Straits Dollars were collected respectively by the two funds.[70] In addition, several ethnic Chinese doctors volunteered to provide free medical treatment and drugs, and were accordingly

[68] *Pinang Gazette Weekly* (henceforth *P.G.W.*). 28 February 1919.
[69] *S.T.* 27 October 1920.
[70] *S.T.*, 29 October 1918.

stationed along five geographical divisions around the city.[71] Although the authorities in Selangor were mainly involved in containing the epidemic, assistance also came from private individuals and groups. In the district of Klang, an improvised hospital catering to mainly Europeans was organised, staffed by European women volunteers residing around the vicinity. [72]

To underline the severity of the influenza among especially the Indian community in the state, the prominent High Street Kuala Lumpur Chetty Temple priest held a public procession by parading a silver-plated car and the Tamil God Supramania across the town on one night and prayers were offered to the victims of the epidemic.[73] A similar Chinese religious event took place in Malacca for the same purpose to ward off the epidemic. Known as the "Wang Kang, the ceremony according to the Straits Settlements official report involved:

A miniature boat (Want Kang) was built and housed in a temporary temple at Banda Hilir until the appointed day in December when it was dragged to the foot of St John Hill and burnt. This ceremony aroused out of the influenza epidemic of 1918, and the underlying idea is propitiation of a deity who has become evilly disposed from neglect. It is thirty years since a similar ceremony was held in Malacca.[74] P. 29

The influenza also brought together the Chinese associations to tackle the epidemic within Selangor. *The Straits Echo* reported a large meeting held at the Chinese Chamber of Mines at Kuala Lumpur, attended by both Chinese doctors and business leaders. A relief fund similar to that in Penang was proposed and doctors pledged their services to patients around their districts while estate owners provided financial support to the fund.[75]

In the neighbouring state of Perak, the British Resident commended on the voluntary efforts of local community groups during the epidemic where:

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[71] *S.T.* 18 October 1918. There were however some who felt that the organisers should go beyond merely providing relief to stamping out what was deemed "profiteers" and "vampires" who exploited the sufferings of the victims. This accusation was targeted at "quack herbalists", "fruit sellers and undertakers who suddenly started to charge exorbitant prices on the victims. A letter written to the *Straits Echo* cited the example of a coffin carrier who demanded three dollars instead of the usual 80 cents which he sometimes repeated three times in the course of a single day. Ibid. 4 November 1918.
[72] *Annual Report for the State of Selangor, 1918,* p. 13.
[73] *S.E.* 21 October 1918.
[74] *S.S.A.R.* 1919. p. 29.
[75] *S.E.* 21 October. 1918.

In Taiping, extra accommodation was obtained from tents lent by the Acting Commandant of the Malay States Guides, and a committee of Chinese gentlemen came forward to visit outlying villages and distributed medicine and other necessities. In Kinta, the native gentlemen, both Chinese and Indians rose finely to the occasion and gave valuable necessities, distributed medicine, blankets and milk, and even bringing the cases to hospitals with their own cars.[76]

Like their counterparts in Penang, the Chinese in Perak started to organise themselves against the epidemic. The Kinta tin mines were divided into four sections where in each section, volunteers and community leaders disseminated public information about the disease in addition to providing food and medicine to the stricken. A conference was also held between plantation owners and leading members of the Tamil community with the view of postponing the Deepavali Festival (Festival of Lights) until the influenza passes over.[77]

Aside from coordinating with the planters, the Indian based associations were also seen conducting relief work amongst the Tamil workers. The volunteers distributed hot congee and blankets and sought leading men in each village to look after their fellow villagers who were affected from influenza.[78] The resources available seemed so overstretched that a wealthy merchant (known as Towkays in the region) Chung Yin Fatt converted his own motorcar into an ambulance, plastered with a logo of the Red Cross, and stacked the vehicle with piles of blankets and boxes of medicine.[79] While it is not certain whether these community efforts were clinically effective against the virus, they nevertheless provided a sense of relief and security. At the very least, the aid offered by the various organisations would have helped pull some from the brink of death or nursing the others back to health.

[76] *Annual Report for the State of Perak*. p. 15.
[77] *S.E.* 22 October 1918.
[78] *T.M.* 31 October 1918.
[79] *T.M.* 22 October 1918.

"Take the Pink Pills to cure influenza"

Across the colony, people were not just relying on government hospitals or dispensaries. They were also seeking prevention and treatment from the medical market.[80] During the period of the epidemic, traditional Malay medicine was granted reluctant acknowledgment as it was widely administered in the countryside. Among those medical formula popularly utilised was a mixture of powdered musk and milk served thrice a day to the patient. It apparently reduced the inflammation of the lungs by forcing out its mucus, thereby relieving respiration difficulties and fever. A less expensive alternative was tea made by boiling cinnamon, ginger, coriander and garlic in equal proportion.[81]

As the *Straits Echo* highlighted, such methods were not prescribed by quacks but by those who were well acquainted with the European medical sciences.[82] The ethnic Chinese community, on the other hand, were reportedly flocking to obtain a formula, which the government considered to be conjured by profiteers. Entailing a mixture of boiled pumpkins, potatoes and coriander leaves, the demand for such ingredients resulted in a rise in their prices. The cost of potatoes for example, rose from a mere 35 cents to $3 per kati.[83] In the meantime advertisements claiming miracle cures and vaccines for influenza proliferated in most newspapers. One prominent message urged those fallen ill to " stay away from work, go to bed early, eat little or nothing, call the doctor" and to take the pink pills" recommended.[84] But, such claims were also met with cynicism from the newspapers like *Straits Times* which commented: "In the uncertainty of our present knowledge, considerable hesitation must be felt in advising vaccine treatment as a curative measure."[85]

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[80] This situation was not unique to British Malaya alone. In his study of the Influenza pandemic in Britain, Niall Johnson observes a flurry of advertisements of remedies against influenza following the reports of an epidemic outbreak. British chemists also saw substantial gains in their earnings during this period. Niall Johnson. *Britain and the 1918-1919 Influenza Pandemic: A Dark Episode* (London, New York: Routledge, 2006). pp. 165-72. The heightened importance and prominence of the indigenous medical market during a public health emergency was also seen in the case of colonial Punjab during the Plague Epidemic in the 1890s. Sivaramakrishnan. *Old Potions, New Bottles.* pp. 53-86.

[81] *P.G.* 22 October 1918.

[82] *S.E.* 4 November 1918.

[83] *S.F.P.* 16 October 1918.

[84] *S.T.* 24 March 1919.

[85] *S.E.* 19 June 1919.

The *Pinang Gazette* was more hostile to the indigenous claims of influenza, believing that these people had "no idea of the disease and how to cope with it [as] the Eastern pathology is primitive and crude."[86] It lamented "quacks and meddling old women are having the chance of their lifetime doing their best to keep up with the heavy death rates." This comment was made in the context of an incident of a man sickened with influenza and allegedly poisoned to death by his elderly mother, who took him to consult European doctors, Chinese druggists and Siamese bomohs (local term for religious healers).[87] Nevertheless, as the *Singapore Free Press* noted for the case of Penang, "Never before has the native population been so earnest about taking preventive as well as curative measures for any diseases as they are doing now."[88]

Behind the reports of the rush for cures, the influenza episode reveals a strong presence of a largely unregulated and increasingly hybridised marketplace of medicine, whose importance was highlighted in this particular health emergency.[89] Even if the medicine men might have individually profited from the public anxieties, they were crucial during this public health crisis in not only providing medical relief. However outlandish their explanations and claims, these practitioners eased public anxieties in a way that government advice and exhortations could not.

Conclusion: Mobilising against Influenza

Taking at least 60,000 lives over just two months in British Malaya, the 1918 influenza pandemic placed severe pressures on the colony. However short its duration, the episode highlighted most poignantly the limitations of the state locomotion while concurrently drawing out the energies of civil society. Taken by surprise by the outbreak, the colonial authorities were unable to make preparations for contingency measures. When asked by a Legislative Council member on the failure to publish a

[86] *P.G.* 1 November 1918.
[87] Ibid.
[88] *S.F.P.* 16 October 1918.
[89] Unfortunately, there have been no studies conducted for the medical marketplace in colonial Malaya even though several vernacular products like Tiger Balm and Eu Yan Sang brands which origins can be traced to this region and period. See: Stephanie Chung Po Yin. "Surviving Economic Crisis in Southeast Asia and South China: The History of the Eu Yan Sang Business in Penang, Hong Kong and Singapore" *Modern Asian Studies* 36.3 (2002): 579-617, and Sam King. *Tiger Balm King* (Singapore: Times Books International, 1992).

military bill, the Colonial Secretary replied that his staff in the printing department had mostly fallen ill to influenza.[90]

Caught off guard by the almost simultaneous outbreaks across the Malayan Peninsula, the medical officials were unable to obtain a clear picture of the epidemiological spread of the influenza as shown by the difficulties in registering mortality rates. Adding to the confusion was an absence of an effective central authority to coordinate relief efforts. Without concrete directions, the containment of the influenza epidemic was left to individual district and municipal authorities and medical institutions. It was unfortunate that most of these departments were inadequately staffed at the senior levels with significant number of officials and resources diverted to the war effort in Europe. Attempts at finding a vaccine from the medical research institute came to nought. Meanwhile, government medical facilities like hospitals were overwhelmed by the massive and sudden influx of influenza related patients.

While the state leviathan was temporarily brought down, it seemed the Lilliputians of colonial society were left to fend entirely for themselves. Among one of the major players struggling to keep the channels of information and social connections open was the colonial newspapers. Collectively, the dailies were able to detect the transmission and severity of the influenza in the colony, provide the latest updates and disseminate the relevant public health information. By reporting on heavily infected places in the peripheral areas as well as details of personal tragedies, the newspapers kept the influenza epidemic in the forefront of the public discussion.

Where the media became a crucial information portal, community groups also rapidly organised themselves to deal with the crisis. Chinese merchant groups and plantation associations established emergency bodies to look after the affected victims or their families, raised funds for relief efforts and organised preventive measures. The influenza episode also provided an insight into the responses of the subaltern levels of colonial society in Malaya. Although frowned upon as unscientific and counterproductive, the religious processions held by the Chinese and Indians served to soothe public anxieties over a supposedly inexplicable evil. In addition, the

[90] *P.G.* 5 June 1918.

promiscuous use and advertisement of medical and pharmaceutical prescriptions underlined the pervasive autonomy of choice of medicine.

So far, the discussions of health lobbies and colonial civil society in British Malaya have been framed within the physical geographies of the municipalities, plantations, hamlets, and in the case of this chapter, the entire colony. The contestations between interests groups and government have been principally staged along the demarcation of responsibility in the management of the land and its inhabitants through the discourses of modern public health. In chapters 6 and 7 however, the tussle takes on a more intangible manifestation. Through the politics of vice in which opium addiction and venereal diseases were construed as its symptoms, temperance movements brought the debate beyond that of the physical space. For these health lobbies, rather than a temporal ground to be made more habitable, the space becomes more of physical representations of moral and civilisational ideals.

The discourses of the idealists bent on shaping a utopian polity however did not necessarily concur with that of the pragmatists contented with a regulated physical entity. This sets the stage in the subsequent chapters on the collision between the regulationists favouring an expedient status quo against the abolitionists campaigning for the eradication of the moral evils of narcotic addiction and venereal diseases from prostitution; a collision of idealised and actualised spaces that further convolutes the experiences of health lobbies in British Malaya.

Chapter 6
Discountenancing Vice: The Anti-Opium Societies

It is alleged, in support of the gaming farm, that by placing it under regulation, the quantity of vice is diminished, but independently of the want of authority of any human government to countenance evil for the sake of good, I cannot admit that the effects of regulation whatever, established on such a principle, are to be put in competition with the solid advantages which must accrue from the administration of a government acting on strict moral principles, discountenancing vice and exercising its best efforts to suppress it.

Stamford Raffles protesting on the toleration of gaming in Singapore.[1]

The difficulties of strictly enforcing prohibitive legislation for the Commission are so insurmountable and the success attending to such legislation so highly problematic that the Commissioners have no hesitation in recording their opinion that except, as the outcome of an international agreement to prohibit the cultivation of the poppy to any greater extent than to suffice for purely medical needs, legislative prohibition would in practice become a dead letter.

Excerpts from the Straits Settlements and Federated States Opium Commission Report, 1908, p. 20

Introduction: Prohibitive Legislation

Shortly less than a year after the establishment of the British colonial outpost in Singapore, its Resident, Major Farquhar proposed establishing Spirit and Opium distribution centres or "farms". Associated prominently with the "discovery" of the island, Stamford Raffles considered it highly objectionable and "inapplicable to the principles on which Singapore was founded."[2] The licences on vices, like opium, alcohol and gambling, were however already issued (in return for revenue to pay for the police force) and Farquhar was subsequently compelled to resign.[3] This episode marked the beginning of the debate in British Malaya between abolitionists and regulationists in the management of "social evils" like opium consumption.

[1] Taken from: Song Ong Siang. *One Hundred Years' History of the Chinese in Singapore* (Singapore: Oxford University Press, 1982) p. 17.
[2] Ibid.
[3] Wakefield. *An Anecdotal History of Singapore*, p. 63.

This chapter places the development of the anti-opium movement in Malaya within several contexts. Until recently, the historiography has been dominated by the accounts of the imposition of European commercial and colonial interests on Asian societies. While acknowledging these trends, historians have nonetheless questioned the extent in which these narratives have distorted the historical perception of opium. With such considerations, the anti-opium movement in Malaya will be examined along its criminalisation from the early 20th century. It further surveys the steps in which the move from mere regulation towards calls for suppression in British Malaya gained momentum during this period from external forces.

It will be elaborated here on how the external lobbies further complicated the opium policies of British Malaya. Moving away from the emphasis on the role of nation-states in determining the pace of abolition, this chapter reviews the part played by the predominantly Chinese anti-opium lobbies. Basically, what is more important here is the extent in which they used the opium debates to platform their interests within colonial civil society. The activities of the temperance movement will be discussed along three areas, namely, their efforts to medicalise and criminalize opium culture, the international networks they sought to connect their struggles, and the rehabilitative clinics established for curing opium addicts. The examination of these activities will provide insights on how medicine and diseases became avenues for social mobilisation by health lobbies utilising social and transnational networks.

No Overdrawn Picture? Historiography of Opium

In 1848, Dr Robert Little observed opium smokers in Singapore who:

"[...]waken to the tortures of the damned when the sun is high up in the horizon, and the industrious of their fellow creatures have been at work for hours: this is the moment they appreciate their wretchedness, when feverish and hot, with a tongue that is dry, yet cannot be moistened, lips that are cracked, yet cannot be soften, a throat parched and thirst excessive, that cannot be quenched, with eyes either closed or running with rheum, a tightness of the chest that prevents breathing, a lassitude, a languor, a pain in all the bones, a downright incapability of exertion, a loathing for food, and a craving for one thing only, which, not to attain is worse than death,-and that is another draught of the poison, which soothes the

moment but clenches the faster the misery of the wretches. No overdrawn picture this, but sketched from life, yea more, by the victims themselves, and of these victims are at least 15,000 in Singapore."[4]

With such popular impressions, the narrative of opium has constantly been written as one of pain over pleasure, injustice instead of indulgence, and, repression over relief. In showing the linkages between opium and colonialism, Carl Trocki highlights:

All countries in Southeast Asia that came under European domination or influence during the 19th century were required to accept the opium trade and at least allow its legalisation for consumption by Chinese immigrants so that revenue could be collected[...]the decision to sell opium by state to subjects also took place in situation of political decline or weakness."[5]

A more sceptical approach towards opium has however begun to emerge. Frank Dikotter observes several entrenched representations of opium as a singularly uniform substance circulated by an immoral political economy.[6] Many historians, he adds, have not substantially observed the diversity of qualities of the herb consumed in complex social settings.[7] With regards to the context of China, Dikotter points out historians have "trained their gaze exclusively on issues of supply and policy, replicating the conventional knowledge that supply determines demand.[8]It is also suspected they may have casually interrogated the opium legacy along contemporary standards of deviance and pleasure. As Stuart Watton highlights:

"Western secularisation has led to a loss of mystical awareness so that divorced from any relation to the spiritual, intoxication becomes merely recreational and hence of no intrinsic value to the modern ideals of personal advancement[...]the hierarchical division (of drugs) not only between the licit and the illicit, but between who may be privileged to partake of the available intoxicants and those who may not."[9]

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[4] Edwin Lee. *The British as Rulers: Governing Multiracial Singapore, 1867-1914* (Singapore: Singapore University Press: 1991) p. 174.
[5] Carl. A. Trocki. *Opium, Empire and the Global Political Economy; A study of the Asian Opium Trade, 1750-1950* (London: Routledge, 1999) p. 89.
[6] Frank Dikotter. Patient Zero: *China and the Opium Myth Plague*. Inaugural Lecture at School of African and Oriental Studies, University of London. 24 October 2003.
[7] Ibid. pp. 3-6.
[8] Ibid. p. 6.
[9] Stuart Watton. *Out of it; A Cultural History of Intoxication* (London: Hamish Hamilton, 2001) p. 8.

In examining its transformation from a medicine to a popular recreation, Zheng Yan Wen underpins the emphasis in exploring the socio-cultural narratives of opium beyond the narrow political accounts of the Opium Wars.[10] Across the Pacific Ocean, Susan Speaker traces the historical foundations of the American anti-narcotic policies as an attempt to simplify complex social issues into a threat against Western civilisation instead of being merely a medical problem.[11] Adopting a less morally blinkered appreciation, RK. Newman argues "if for the Chinese, opium growing and smoking were 'normal rather than deviant activities[...]it is the implication of this normality which ought to be explored, both for the sake of China's history and for the sake of their relevance to modern societies learning to live with drugs."[12]

The same controversies of the politics of pleasure should be posed in the context of British Malaya. As a prevalent form of popular indulgence, a major economic activity and a cause of intense debate, the opium culture in the colony has received substantial scholarly attention. The reports generated from frequent reviews of policies pertaining to the regulation of opium, particularly the detailed proceedings of the government appointed commissions of 1908 and 1923 have served in revealing the politico-legal dimensions of the colonial administrative machinery.[13] Underlying these official narratives are layers of activities surrounding the opium culture that historians have excavated.

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[10] Zheng Yangwen. "The Social Life of Opium in China, 1483-1999", *Modern Asian Studies* 37,1. (2003):1-39.

[11] Susan L. Speaker. "The Struggle of Mankind against its deadliest foe", *Journal of Social History* 34:3 (2001):591-610.

[12] Juan F. Gamella (ed). *Drugs and Alcohol in the Pacific; New Consumption Trends and their Consequences*. (United Kingdom: Ashgate, 2002). pp. xxxiii-xxxiv. See also: R.K. Newman, "Opium smoking in Late-Imperial China: A reconsideration", *Modern Asian Studies*, 29: 4 (1995): 765-94.

[13] Lena Cheng U-Wen. "Opium in the Straits Settlements", *Journal of Southeast Asian History*. Vol. (1961). "British Opium Policy in the Straits Settlements, 1896-1910", *Journal of Southeast Asian Studies*, 2:1 (March 1961): 52-75. Ernest Chew. "Opium Smoking and Gambling in the Malay States, 1896-1942: The Official View", *The Historical Journal* (1963): 33-35.

This includes the study of opium "farms" in Malaya by historians as part of the relationship between British colonialism and Chinese business networks.[14] Being one of the "four evils" of gambling, prostitution and alcohol, opium became a manifestation of the pastimes and woes of the Chinese working class in James Warren's *Rickshaw Coolie*.[15] As such, the activities of anti-opium societies have also been acknowledged as part of the general trends of Chinese nationalism and ethnic Chinese led social movements in the colony.[16] A common assumption running through these works has been the portrayal of good anti-opium fighters against exploitative narcotic regimes. Even as these views have been canonised into the historiographical mainframe, the moral certainty of their presuppositions of the otherwise socio-medico complexities of opium remains to be interrogated.

Taken in Moderation: Opium in Malaya

The Opium trade had been inextricably linked to the British presence in Malaya. Located between the Straits of Malacca and the South China Sea, the Malayan Peninsula was historically a major maritime route between China and India. The newfound demand of the Chinese market for Indian processed opium heightened the need of the British East India Company for a transhipment point within the Dutch controlled Malay Archipelago in the early nineteenth century. It was in Singapore where the British finally established a trading settlement for this purpose.[17] Trocki points out the vital role of opium in the "capitalistic transformation" of local economies and revenues.[18] The opening up of the Treaty Ports in China raised Malaya's position as a distribution centre more prominently. Simultaneously, opium found a growing domestic demand particularly from the burgeoning Chinese immigrant population.[19]

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[14] See: John Butcher. "The Demise of the Revenue Farm System in the Federated Malay States", *Modern Asian Studies*, 17:3 (July 1983): 64-114, Carl Trocki. *Opium and Empire: Chinese Society in Colonial Singapore, 1800-1900*, and "Opium and the beginnings of Chinese Capitalism in Southeast Asia", *Journal of Southeast Asian Studies*, 36:2 (2002): 297-314, Yeh Ching Hwang. *Community and Politics: The Chinese in Colonial Singapore and Malaysia* (Singapore: Times Academic Press, 1995) pp. 147-174.

[15] James Warren. *Rickshaw Coolie: A People's History of Singapore, 1880-1940* (Singapore: Oxford University Press, 1986) pp. 236-257. See also: Manderson. *Sickness and the State*, pp. 141-2.

[16] See: Hong Lysa. *The Intellectual Awakening and Social Reforms of the Chinese in Singapore, 1894-1910* (Honours Thesis: National University of Singapore, 1975), Patsie Tan Cheee Peng. *The Anti-Opium Campaign in pre-1942 Singapore* (Honours Thesis: National University of Singapore, 1992). Yeh Ching Hwang. *Community and Politics*, pp. 197-163.

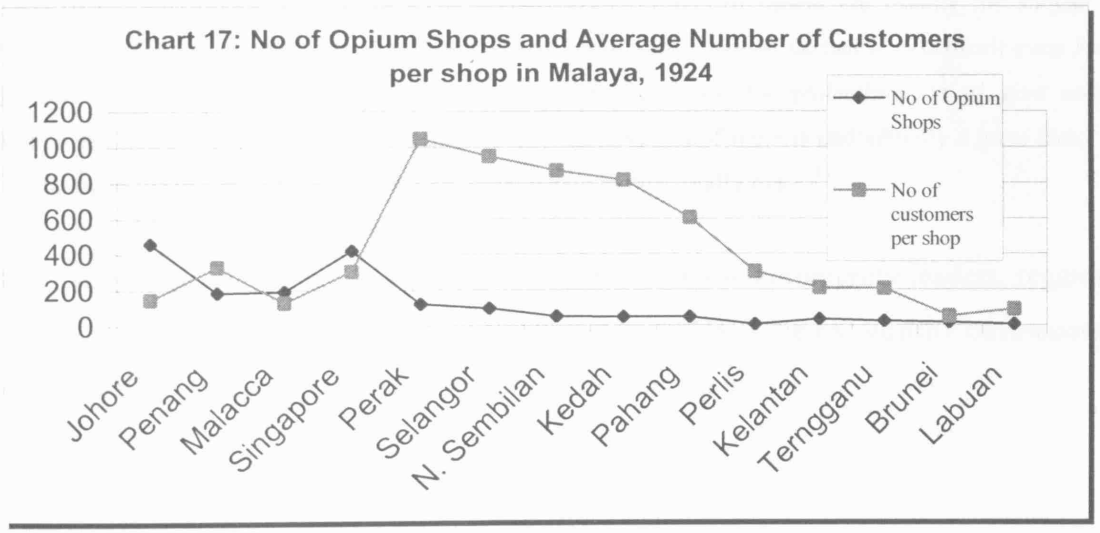
[17] Trocki. *Opium and Empire*, pp. 50-81.

[18] Trocki. *Opium, Empire and the Global Political Economy*, p.173.

[19] Trocki. *Opium and Empire*, pp. 50-81.

Around the herb, an entire culture of pleasure in Malaya flourished. Its narcotic value was shared by the wealthy merchants in brothels and opium dens, and also by Malay sultans in their palaces. Its prophylactic values were recognised by coolies as relief to the harsh working conditions and living environments.[20] As the Straits Settlements Secretary for Chinese Affairs responded to an International Labour Organisation Enquiry into the relationship between Opium and Labour: "The harder and more killing the labour is and the more beastly the conditions in which the labourer lives, the greater the temptation."[21]

Chart 17 shows the degree of availability and accessibility of opium shops to adult ethnic Chinese males in the colony. The ease of access to these retail outlets was greater in the urban territories of the Straits Settlements with a larger population density served by comparatively more opium shops than in the Peninsula. In the Federated Malay States where the population was more scattered, there were comparatively fewer opium shops, with Perak registering the highest of 1,049 potential customers per shop (see Table 27 in Appendix 5 of Annex A).



Source: British Malaya Opium Committee: Report of the Committee appointed 27 November 1923 (Singapore: Governement Printer, 1924) p. A25. see Table 27 of Appendix 5 of Annex A for details.

[20] PRO/CO882/5/18. "Memorandum on the use of opium for the Royal Commission for Opium in 1894."
[21] According to the Straits Settlements submissions to the Enquiry, of about 24,000 registered smokers, close to half were tin miners and rickshaw pullers. PRO/CO825/23/5. "ILO Opium and labour studies and report Geneva 1935."

Until the early 20th century, the medical opinion in British Malaya had little comment on the use of opium against common illness and diseases.[22] Aside from the occasional protests from missionaries, opium was not generally regarded as harmful. On the contrary, there was a staunch belief in British Malaya that the opium economy was linked to the liberal foundations of free trade in which the prosperity of the colony depended. This was not merely the views of the European business community. In valorising the prominent personalities in the ethnic Chinese community in British Malaya as successful merchants, altruistic philanthropists and national patriots, mainstream historiography has kept mum about their participation in the opium trade. What has been selectively sidelined in the process was that until the early 20th century, there were little moral misgivings of the ethnic Chinese in Malaya against the poppy. During the first international Royal Commission for the Suppression of Opium, many prominent Chinese merchants even testified the benign effects of the drug if "taken in moderation."[23] Similarly, the Opium Committee of 1908 in the Straits Settlements was reluctant to criminalise opium on medical grounds:

> We cannot consider that the tendency for the evidence supports us in the opinion we have formed, as the result of our investigation, that the evils arising from the use of opium are usually the subject of exaggeration. In the course of the evidence, it has been pointed out to us that it is difficult even for a medical man to detect the moderate smoker[...]The tendency for philanthropists to give undue prominence to such bad cases and to generalise the observation of them is undoubtedly a great factor in attributing to the use of opium more widely extended evils than really exist. [24]

The Committee, comprising of prominent ethnic Chinese community leaders, regarded opium as an acceptable indulgence personified probably more by wealthy businessmen and industrious coolies rather than the emaciated opium addict.

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[22] As mentioned in the Report of the 1908 Commission in the Straits Settlements on the Opium question: "With the exception of some medical practitioners who hold views strongly opposed to opium, the medical witnesses are practically unanimous in expressing the opinion that opium smoking in moderation is relatively harmless." Straits Settlements and Federated Malay States Opium Commission. *Proceedings of the Commission appointed to inquire into matters relating to the use of opium in the Straits Settlements and the Federated Malay States. 1908* (Singapore: Government Printing Office: 1908). p. 12.

[23] For submissions from officials and private individuals from the Straits Settlements, see: PRO/CO882 5.18. Eastern No 63. "Correspondences on the subject of Opium in Hong Kong and the Straits Settlements. August 1896.

[24] Straits Settlements and Federated Malay States Opium Commission. *Proceedings of the Commission appointed to inquire into matters relating to the Use of Opium in the Straits Settlements and the Federated Malay States.* 1908 (Singapore: Government Printing Office: 1908). p. 13.

The tide against the permissive narcotic culture was however beginning to turn. As the British Empire was bound increasingly by international obligations on opium suppression, their colonial administrators were compelled to review their liberal local opium regimes. The prelude of such moves came during the 1893-95 Royal Commission on Opium.[25] Its surveys and findings placed the opium policies of the various colonies under intense public scrutiny from London. While the inconclusive judgement about the harmful effects of opium disappointed the temperance movements in Europe,[26] it did nevertheless put the authorities in Malaya on the defensive.[27]

"The Black Spot of the International Opium Problem"

The 20th century marked the beginnings of the concrete global drive towards the suppression of opium. Beginning with the joint agreement in 1906, committing Imperial China and the West to the elimination of the production of opium, further resolutions were undertaken in the various international opium conferences in 1912 and 1915.[28] A more concerted impetus came from the Opium Advisory Board and the Central Opium Board established by the League of Nations to oversee the eventual suppression of the opium trade.[29] A paramount feature of these boards was their roles in holding member states publicly accountable for their narcotic policies through obligatory submission of relevant data on the production, revenue, smuggling and consumption of opium.[30] These figures were in turn openly scrutinised and debated by national representatives during the quarterly meetings of the Central Opium Board.[31] In spite of specific differences

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[25] For details of the proceedings and reports of the commission, see: *Royal Commission on Opium* (London : Eyre & Spottiswoode, 1899).

[26] *Royal Commission for Opium*, Vol. 7, p. 153

[27] Meanwhile, the Colonial Office came under increasing public at with the embarrassingly high revenue derived in Malaya from the vices of opium and gambling. The Undersecretary of State for the Colonies, Winston Churchill explained to Parliament of the need to proceed slowly with these issues in order not to seriously disrupt the customs and lifestyles of the Chinese. Nonetheless, the demands of London compelled Malaya to tighten its regulations on legalised vice, ranging from reducing operating hours to limiting licensing zones. Butcher, "The Demise of the Revenue Farm System in the Federated Malay States", *Modern Asian Studies*, p.402.

[28] See: Thomas D. Reins, "Reforms, Nationalism and Internationalism: The Opium Suppression Movement in China and the Anglo-American Influence, 1900-1908", *Modern Asian Studies*, 25:1 (February 1991):100-142.

[29] Jean Siotis, "The Institutions of the League of Nations", in *The League of Nations in Retrospect* (Berlin, New York: Walter de Gruyter, 1983) pp. 27-8.

[30] See: Central Opium Board, *Report to the Council on the Statistics of Narcotics*..

[31] See: Report to the Council on the work of the Central Board during its Fourteenth, Fifteenth, Sixteenth and Seventeenth sessions and on the statistics for the year 1932: supplied in virtue of the Opium Convention signed at Geneva on February 19th, 1925 (Geneva: The League of Nations, 1933).

among member states, the League managed to carve a broad international consensus by the 1930s regarding the eventual suppression of the opium trade.

As reflected in the disputes between Raffles and Farquhar concerning vice, there was a degree of acknowledgement on the need for regulation in British Malaya. In an apparent retreat from his moral ideals, Raffles framed the principles of what would be seen as the beginnings of the regulatory regime on opium in the colony in 1823.

> The use of spirituous liquor, though innocent in moderation, becomes vicious when indulged in excess: the consumption may be diminished by the enhancement of price: and in this way the indulgence may be made so expensive...[hence] the use of opium and spirituous liquor may be repressed by exacting a heavy tax in the way of license from the vendors.[32]

In light of the increasing hostility towards the opium traffic, the governing principles behind the licensing system were no longer uncritically accepted. But, the governors were not altogether convinced of the wisdom of immediate abolition.[33] Whilst the lucrative opium profits were often regarded as the paramount reason for official reluctance, the issue of a sudden criminalisation of the habit was not lightly dismissed. Any drastic withdrawal of opium supplies was feared to be dangerously impractical.[34] With porous borders, voluminous movements of goods and people, the enforcement of such lofty principles was deemed unfeasible.[35]

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[32] Wakefield. *An Anecdotal History of Singapore*. pp. 112-113.

[33] One of the earlier initiatives undertaken by the colonial administration was the investigation of the complaints by British Residents in the Malay States of the practice by Chinese mining and plantation contractors of buying opium on behalf of their workers. This was part of the "Truck System" whereby contractors would arrange for the purchase of daily necessities in especially isolated mines and plantations. The investigations concluded that due to a lack of recreational and medical facilities in these areas, opium became the only form of relief for these coolies and that the contractors did not charge exorbitant rates for such delivery services. PRO/CO273/330. No. 20547. "Federated Malay States: Truck System: Investigation into practice of paying part of wages to Chinese miners with opium." 10 July 1907.

[34] For example, shortly after the announcement of further restrictive measures in controlling opium smokers, the authorities received a petition from proprietors of the opium retail outlets appealing for a delay in the withdrawal of their licences. PRO/CO 273/531. C.10300. "Petition for renewal of retail opium licences". 17 May 1926

[35] As a memorandum explained, unlike Hong Kong, the 1,230 miles of the coast line of the Malayan peninsula would render "ill-considered restrictions" almost impossible to enforce. A more complicated issue was however the anticipated fall in revenue should immediate abolition set in. London was also reminded that Malaya was by no means a homogenous whole where British authority over the Malay States was not overbearing. Getting the agreement of not just the local Governor but also the sultans to make radical reductions to their revenues would result in significant displeasure and resistance. Finally, the memorandum felt the timing of the reduction of opium consumption in Malaya was inappropriate in light of the worsening situation of poppy production and smuggling in China. PRO/CO 882/11. Enclosure 4. No. 32. "Opium Policy: Colonial Office Memorandum. 21 July 1924. See also: Derek Mackay.

Until the late 1930s, the colonial administration struggled to define and refine its opium policies. This came in several stages beginning from the control of production in the early 1900s whereby the import, manufacturing and retail of opium were leased to syndicates known as "opium farms. These licences were subsequently replaced by state monopoly in 1908 following the recommendations by a committee calling for stricter supervision.[36] More restrictions were imposed based on the feedback of another committee in 1924.[37] On the side of consumption, a mandatory registration of certified opium smokers who were to be subjected to a rationing system was introduced. In turn, an Opium Replacement Fund was formed to mitigate the expected financial losses from the reduced consumption.[38] Under this scheme, ten percent of the colony's annual revenue was set aside to make up for the eventual reduction of the earnings.[39] Chart 18 below reflects on the proportion of opium profits to the general revenue and the implications of restrictions. Within a decade from 1919 to 1929 the opium revenue registered a general fall from two fifths of the colony's revenue to about fifteen percent.

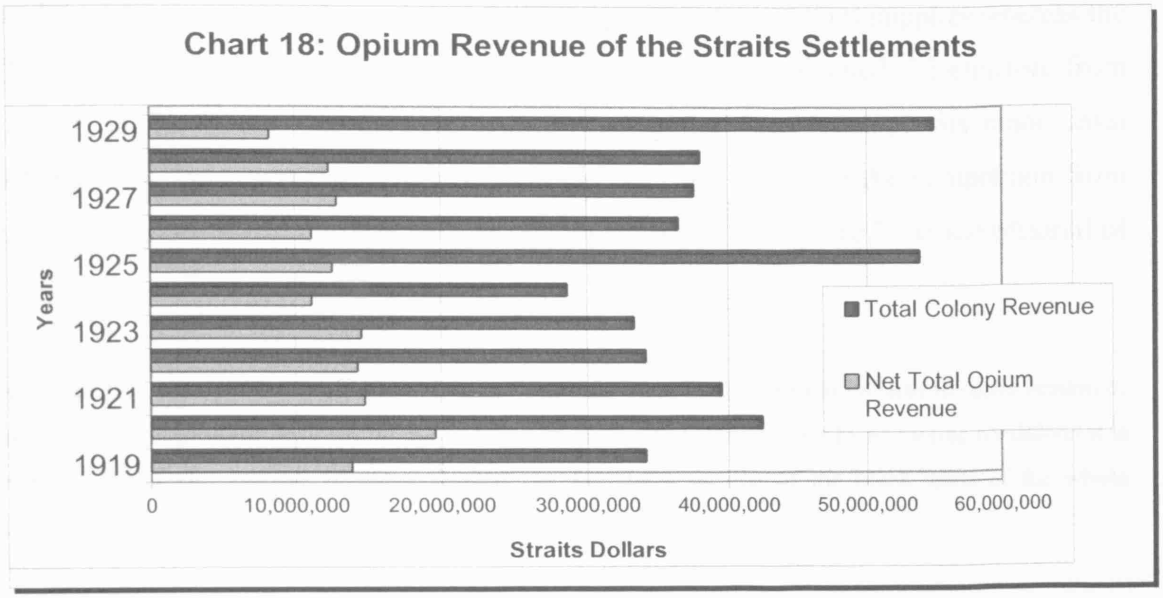
Eastern Customs: The Customs Service in British Malaya and the Opium Trade (London : I. B. Tauris, 2005).

[36] Butcher suggested the intent of monopolising the opium farms was to raise revenue, Butcher. 'The Demise of Revenue Farm System in the Federated Malay States.' p. 411. However, this process worried the colonial administration initially. Governor John Anderson warned the Colonial Office: "This regulation was reluctantly carried out by the Straits Settlements government I venture to remind Your Lordship that any measures for diminishing the consumption of opium will seriously affect the revenue of the colony and I hope that when, on the termination of the existing farm we are in a position to take further steps towards discouraging the use of opium, the resulting loss of revenue will be followed by a corresponding reduction in military contributions." PRO/CO273/338: No,. 424, 13 November 1908. John Anderson to CO on report of Opium commission.

[37] Straits Settlements: British Malaya. *Opium Commission Appointed by His Excellency, the Governor and the High Commission to inquire into matters relating to the use of opium in Malaya* (Singapore: Government Printing House, 1924).

[38] For details of the regulatory policies, see: League of Nations. *Commission of Enquiry into the Control of Opium Smoking in the Far East*. Volume Two (Geneva,1934) pp. 47-132.

[39] A Committee was appointed in 1925 to set up the Opium Reserve Funds based on the principles of the Hague Convention of 1912 which stipulated signatories to "reduce consumption of prepared opium in territories under their authority within the period of fifteen years. The committee recommended that a sum of $30million should be appropriated as the nucleus of the fund and that an annual contribution of ten percent of the revenue be made to it. The duties from liquor, tobacco and petroleum should also be increased to add to this fund. No.30 of 1928. Straits Settlements: *Report of Opium Revenue Replacement and Taxation Committee*. 30 January 1928. p. 2 (NUS Libraries: Singapore Malayan Collection).



Source: League of Nations: Commission of Enquiry into the Control of Opium in the Far East (Geneva, 1934) pp. 69-70.Note: See Table 28 in Appendix 5 of Annex A for details.

To the colonial administration, regulations were secondary to the reduction of opium consumption. Governor Shenton Thomas reported that opium smoking establishments eased completely in the Malayan Peninsula in general with opium shops dropping substantially from thirty to four in the Federated Malay States.[40] Meanwhile, the licensing regime was tightened considerably for opium smokers.[41] For Shenton Thomas, the more important attribute was the general improvements in standards of living in the colony. With the increasing availability of public entertainment and sporting facilities made more accessible by the expansion of public transport infrastructure, he concluded there was less incentive to resort to opium.[42]

The colonial government, however, faced considerable displeasure in such readjustments, which were thought "to be a muddle of motives and social attitudes that was never unanimous in its intention, except to avoid the abolition of opium smoking."[43] It was accused of either being too radical by regulationists or too timid by

[40] PRO/CO 882/18. No. 55001/35 [No.7]. "From Governor of Straits Settlements to Secretary of State for the Colonies." 9 May 1935.
[41] Ibid. No. 55001/35 [No.1]. 2 January 1935.
[42] Ibid. No. 550001/35 [No.7]. 9 May 1935.
[43] Warren. *Rickshaw Coolie*. p. 248.

abolitionists. Opium retailers protested at the appropriation of their supplies whereas the effectiveness of the enforcement of the monopoly was questioned.[44] Detractors from Geneva to Singapore expressed discomfort with the occasional profits made from official sales, lamented the lack of a parallel effort in countering the competition from smuggled opium and the influx of new opium smokers from China.[45] As the editorial of the *Singapore Free Press* complained:

> At a time where Malaya is doing probably more than any other administration towards the achievement of the ideal of total prohibition-even though that action is largely forced upon it by economic conditions-it is curious to find that Malaya is being singled out for attack as one of the black spots of the whole international opium problem.[46]

Meanwhile, expressing impatience at the apparently "gradualist" revisions, abolitionists questioned aloud the sincerity of the colonial government in solving the opium evil. Questions were also raised from various quarters on the financial burden the colony would have to bear from the Opium Replacement Fund and the fear of its possible misappropriation by London.[47] The cacophony of arguments was also joined by those who continued to believe firmly in the non-addictive effects of opium. As late as 1936 the *Straits Times* editorial insisted:

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[44] A memorandum was submitted by a delegation of opium shopkeepers appealing against deliberations of the colonial government to appropriate their shops under an official monopoly in 1923. While expressing in principle support for the eventual suppression, they argued against the registration of opium smokers which they claimed was difficult to enforce and open to abuse. *SSLCP*. 1923. Appendix LXXVII: Translation of the Memorandum by Opium Shopkeepers[in Singapore] to the Colonial Secretary, Straits Settlements, p. B121.

[45] See: Alfred Sze Sao-Ke. *Geneva Opium Conference: Statement of the Chinese Delegation* (Baltimore: Johns Hopkins Press, 1926).

[46] *S.F.P.* 5 November 1933.

[47] The Governor stated he was "aware that apprehensions are entertained in certain quarters lest the possession of this financial nest-egg by the Colony should tempt the Imperial Government to seek to divert it[...]to purpose other than those which the public of the Straits Settlements would regard as best adapted to its interests." He was however assured by London that such diversions would not take place. Nonetheless, the Committee for Opium Revenue Replacement and Taxation was convinced this statement did not calm the "widespread fear" about the temptations of the fund to London. Ibid. p. 3. The colonial administration also expressed apprehension of provoking widespread opposition from the colonial civil society over the Opium Replacement Fund. It felt "the educated Europeans and the better educated of the Asiatics are at heart not seriously dissatisfied with a form of government under which they carry on their business in safety. They regard the agitations as mainly academic and do not take them very seriously. But, if their pockets are touched, or the objects which they have at heart are thwarted, their attitude is very different and their opposition to government becomes organised, and something to be reckoned with." PRO/CO54/882/10. C. 20941/26 [No. 8]. "Extract from a Confidential Despatch from the High Commissioner, Federated Malay States, to the Secretary of State for the Colonies, 9 November 1926.

"With equal candour, we will add our own opinion: which is that so long as those conditions remain as they are today the coolie should be allowed to have his opium in moderation so long as he wants it. Alcohol, tea and coffee are all mild drugs, used to ease the strain of modern life, and opium is in exactly the same category."[48]

The difficulties of the Malayan government was well recognised by the Colonial Office which felt compelled to defend its policies against the mounting criticisms of the League of Nations.[49] Explaining the colony's measures to an increasingly frustrated Foreign Office, the Undersecretary of State for the Colonies wrote to his counterpart:

We have known for a long time that there is a strong feeling among the high officials in (Hong Kong as well as Malaya) who have a great deal with this business that the Far Eastern Colonial Governments have, in the past three years been most unduly "harried" over the opium question. They are all so definitely convinced that, in existing circumstances, to try to bring about effective suppression of opium smoking is like beating the air, and they cannot understand why other people cannot be made to see it. They strongly resent being constantly urged to take measures which they feel can have little, if any real effect, and which if imposed prematurely and without any due and careful preparation, are liable to be bitterly resented by the people they are governing. There is ever present in their minds the possibilities of disturbances (as occurred in 1920) when illiterate coolies were arbitrarily denied of their accustomed supplies. They are also conscious of the more insidious dangers to the good government of their territories which is threatened by the almost inevitable growth of corruption among the Asiatic staff of the opium control departments.[50]

However, this appreciation from London complicated the British Empire's international obligations on opium. Having made to account for the increase in opium revenue in Malaya when it was committed to its suppression, the British representatives found "difficulties in rationalising the situation". As stated by the Colonial Office to Governor Guillemard,

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[48] *S.T.* 14 January 1936.

[49] The continued increase in opium revenues in the Straits Settlements during the 1920s was placed under scrutiny on several occasions by the representatives of the Opium Advisory Committee. The British representative, Malcolm Delevingne justified the hike on grounds of catering to more smokers arriving from China and the need to compete with smugglers. League of Nations Advisory Committee on Traffic on opium and other dangerous drugs. Minutes of 11th Session 12-27 April 1928. p. 22 (Wellcome Library)..

[50] PRO/CO54/882/10. C.20941 [No 12]. From L.S. Amery, Secretary of State for the Colonies to A. Chamberlain, Secretary of State for Foreign Affairs. 21 December 1926.

Our representatives at Geneva feel that, if tackled on the subject, they will have the greatest difficulties in persuading any international gathering that such a large increase in consumption of chandu, as has taken place in Malaya, is consistent with the discharge of our obligations for the gradual and effective suppression of opium smoking and that these difficulties are increased by the fact that the Malayan governments make large profits out of every ounce of opium that is sold[...]As a political question, the topic of opium is very much alive[...]I do feel that the various acts and omissions your government has not been nearly so helpful as it might have been, acts and omissions which not only are likely to put our representatives at Geneva in a very embarrassing position, but which also makes it very difficult to convince my colleagues that Malaya is really doing as much as it can reasonably be expected to do.[51]

This issue continued to surface throughout the 1930s in Geneva and London. While praising the Straits Settlements for significantly reducing opium consumption, the Secretary of State for the Colonies, Malcolm MacDonald was displeased that: "on moral grounds that it is undesirable that the Far Eastern Governments should continue to derive substantial revenue from a traffic which they have undertaken to suppress."[52]

It was also during the Second World War that the gradualist approach of opium suppression gave way to the more ambitious intentions of the Americans at total abolition. The US government was both eager to use the anti-opium messages as a propaganda tool aside from fearing the temptations of its soldiers to narcotics should they wrest control of those areas from the Japanese. As such, under pressure from the Americans who expressed the "right to take independently in all localities where its military forces may be operating, suitable measures which be deemed to be necessary for the protection of health of its forces" on outlawing opium consumption, London relented.[53] On 10 November 1943, His Majesty's Government announced a total prohibition in British protected territories in the Far East then in enemy occupation.[54]

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[51] PRO/CO54/882/10. C.20941 [No. 19]. "Private letter from L.S. Amery, Secretary of State for the Colonies to Laurence Guillemard Governor, Straits Settlements and High Commissioner, Federated Malay States. 1 February 1927.
[52] PRO/CO882/18. No 55036/38 [No. 25]. "From Secretary of State to Governor."
[53] PRO/CO825/30/2. "Opium Postwar Policy." 25 October 1943.
[54] Troki. *Opium and Empire*. p.215

"Making it distasteful": The Anti-Opium Movement

The commitments of governments towards the suppression of opium cultures might not have been forthcoming in the absence of international developments. This was a view that has been expounded by Harumi Goto-Shibata who concluded: "Without the pressure from the United States and the wider international society, it is doubtful whether Britain would have made as much effort to eradicate the opium problem in the Empire." [55] Nonetheless, while regulatory policies were validated in international agreements, their implementation was dependent upon local support. This was highlighted by Governor's Guillmard's note to the Colonial Office on the 1924 Straits Settlements Opium Committee Report:

> I would call your attention to Section XIII of the Committee's report "The Chinese Community in British Malaya and the Anti-Opium Movement" which throws light on the extent to which "willing co-operation or at any rate the acquiescence of the Chinese themselves may be relied on in connection with measures taken locally, and especially to Paragraph 17 which runs as follows: "We feel impelled to utter a warning "that government cannot rely on the active and continuous support of the Chinese Community in carrying out measures "which will be distasteful to an appreciable portion of that "community". It is quite possible that when the report is published this particular section of it will evoke much comment in the local press, but I believe that it represents the real position accurately and reasonably, and it has a very definite bearing on the whole question of the action to be taken.[56]

In this respect, it was also the anti-opium movement in British Malaya that magnified the evolving global conscience onto the local context. As a comment in the *Penang Gazette* noted, the "establishment of the [anti-opium] Association among Chinese themselves is more likely to lead to government intervention for the suppression of opium traffic than the hysterical agitation carried out by well meaning but misinformed busybodies at home [in Britain]."[57]

There were several functions of the anti-opium movement in British Malaya, namely, institutionalising the otherwise disparate abolitionist lobbies, promoting public awareness, and provision of opium treatment centres. While anti-opium societies were prevalent in Western Europe, America and China from the mid 19th century, the

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[55] Harumi Goto-Shibata. "Empire on the Cheap: The Control of Opium Smoking in the Straits Settlements, 1925-9", *Modern Asian Studies*. 40:1 (2006): 59-80. p.79

[56] PRO/CO273/525. "Governor Guillmard to Colonial Office." 18 March 1925.

[57] *P.G.* 14 November 1906.

formation of similar organisations took root in British Malaya in 1906. Although the first Anti-Opium Society was allegedly attributed to an apparent surge in interest to a newfound cure of the opium addiction from herbs discovered by Chinese rubber tappers, broader socio-political developments were responsible for its founding.[58] The early 1900s coincided with the revolutionary movements gaining momentum in China as anti-Manchu republicans sought support from overseas Chinese under the banner of nationalism. In this respect, the opium culture was exploited as one manifestation of China's weakness. Dikotter asserted this war on drugs:

> Allowed political leaders and social elites in China to invent a fictive enemy on to whom social anxieties could be projected: Nacrophobia created a scapegoat. Opium represented both the enemy within-the morally depraved and physically weak addict-and the enemy from outside-conniving foreign powers bent on enslaving the country. Opium became the rallying ground which social unity could be asserted, as both addicts and imperialists emerged as the ultimate alter ego against which national identity could be defined. Peddled by imperialist powers, insinuating itself into the bloodstream of the nation, poisoning the minds and bodies of the country's millions, opium gradually became a symbol of national weakness, the cause of a massive failure of the will.[59]

These emerging sentiments towards the opium culture were not confined only to China, but disseminated to overseas Chinese.

The driving force came from a distinct generation of mainly Straits-born Anglicised ethnic Chinese elite who came into political maturity around the turn of the century.[60] Among them were Dr. Wu Teh Lien,[61] Dr Lim Boon Keng,[62] Dr Yin Suat Chuan,[63] and

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[58] *S.T.* 1 October 1907.
[59] Dikotter. *Patient Zero.* P. 16.
[60] See: Yong Ching Fatt. "A Preliminary Study of Chinese Leadership in Singapore", *Journal of Southeast Asian History* 9.2 (September 1968): 258-286.
[61] Dr Wu Lien The (Goh Lian Tuck) was born in Penang in 1879. He received his medical training in Britain and served in the Liverpool School of Tropical Medicine before returning to Malaya to spend a year at the Kuala Lumpur based Institute of Medical Research in 1903. He subsequently served in China as an epidemiologist in the 1910s and represented the Chinese government in the Central Opium Board in the 1920s and 1930s. A. Wright and B.A. Cartwright: *Twentieth Century Impressions of British Malaya* (Singapore: 1908) p. 160.
[62] Dr Lim Boon Keng was born on 18 October 1869. He was the first Queen's Scholar from Malaya to study medical sciences. He returned in 1893 and entered into private practice. He was subsequently appointed as the Chinese representative on the Straits Settlements Legislative Council where his broader social role emerged. Ibid.
[63] Born in Amoy in the Fujian province in 1877, Dr Yin Suat Chuan came to the Straits Settlements as an interpreter to the local Police Courts in 1898. Between 1899 and 1903, he studied in various American and British medical colleges and returned to join Dr Lim Boon Keng's private practice in 1904. Ibid.

Dr Chen Su Lan,[64] all Western trained medical doctors who were either educated in Britain or the Medical College in Singapore. Likely to be influenced by the notions of degeneracy as well as Chinese nationalism, they had probably less sympathy towards the opium habit than their predecessors.

More important than their grasp of Western medical knowledge was the familiarity of these Straits-born Chinese with the workings of the colonial administration and culture of civil society. This gave the British rulers the crucial trust and assurance of their political loyalties to the Crown. As reported by Governor Gullemard in the representation of the Chinese in the 1924 Straits Settlements Opium Commission:

> In Malaya, it is difficult to find China-born Chinese with sufficient knowledge of English to justify their selection as members of a committee of this nature, and in the present state of feeling as regards opium it is on the whole better that the Chinese members should have been chosen from the Straits born section of the Chinese community, who take a far stronger line on the opium question than the China born. The fact that leading Straits born Chinese have subscribed to a very gradual programme is to my mind a clear indication that after careful examination, they realised that in view of local circumstances gradual progress only is possible.[65]

In the 1910s-1930s when Chinese revolutionary activities were rife in Malaya, the Straits-born Chinese were increasingly valued as being the more moderate faction.[66]

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[64] Dr Chen Su Lan was born in the Chinese Province of Fuzhou in 1885 to a widowed mother, who was a devout Methodist. He spent his formative years in the Anglo-Chinese College in Fuzhou before pursuing his medical education in Singapore. He was among the first graduates of the King Edward VII College of Medicine, established in 1905. See: Liew Kai Khiun. "Chen Su Lan, in Bill Bynum and Helen Bynum (eds). *Dictionary of Medical Biographies, 5 volumes.* (USA: Greenwood Press: 2006).

[65] PRO/CO273/525. "Governor Guillemard to Colonial Office." 18 March 1925.

[66] Although chastising the Governor for arbitrarily outlawing its branches in Singapore for fear of repercussions on British interests in China, London nevertheless acknowledged "potentially the Kuomintang might become a menace to British rule in Malaya." This reflected the British suspicions of what they perceived as the more radical and destabilising activities diffusing from China. (Compilation of PRO records of the Kuomintang in Malaya, 1930-31 by the Central Library of the National University of Singapore. REF: SMC. DS596.3Act).

As an institution, the anti-opium societies provided a front for garnering financial and moral support, organising public events and promoting public discussions.[67] These groups were also crucial in establishing broader international and regional networks with temperance groups. The inauguration of the society generated visible public enthusiasm and inspired the duplication of similar chapters in each of the Malay states and the Straits Settlements. Keen to sway official policies, the various anti-opium societies publicly lobbied for their cause through open letters, petitions and making representations in state appointed committees.[68]

Being a tool for building public consensus, one of the earliest successes of the anti-opium societies came in securing the commitment of the merchant community to the suppression of the opium trade.[69] Shortly after its establishment, the Singapore Chinese Chamber of Commerce publicly pledged to work towards ending the involvement of Chinese merchants in the opium industry.[70] Although this seemed superficial, it nevertheless bound the merchant community morally to the abolition cause. The Society also took steps to co-opt ordinary businesses into supporting the movement. At a meeting on 3 October 1907, about 1,600 local Chinese shopkeepers formally agreed to refrain from employing opium addicts.[71] When it came to the calls for financial support for the anti-opium clinic by Dr Chen Su Lan in the late 1920s, donations were forthcoming.

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[67]While Anti-opium societies were prevalent in both the Straits Settlements and the Federated Malay States, they did not function as a uniform organisation. On the contrary, the level of activities and memberships in these societies in the individual territories varied. The Perak and Selangor branches consisted of about 200 Straits born and Chinese members. During the 1920s, the Singapore Anti-Opium Society was seen to be moribund while the Secretary of the Selangor branch admitted that their grouping faced a "somewhat fitful existence." *Report of the Straits Settlements Opium Commission, 1924.* A45-6.

[68] The official representatives of the Anti-Opium Societies were Dr R.M. Connolly for Perak, Loke Chow Thye and Tan Pow Teck for Selangor and Tay Seck Tin for Singapore. Other members of the Anti-Opium Societies also gave evidence in their capacities as tin miners, rubber planters and representatives of trade associations. Jansen. *The British Malaya Opium Committee Report, 1924.* p. 17.

[69]The sympathies from the merchant elites towards the temperance movement corresponded with their increasing disenfranchisement from the opium economy. Having their businesses appropriated by the state, it became less problematic for them to support the local anti-opium movement.

[70]In a meeting of the Singapore Chinese Chamber of Commerce in 1907, several resolutions covering the ban on opium in public places and its eventual abolition was passed. Tan. *The Anti-Opium Campaign in pre-1942 Singapore.* p.61

[71] Yeh Ching Hwang. *A Social History of Chinese in Singapore and Malaysia, 1800-1910.* (p. 236. This stirred up some enthusiasm from local Chinese merchants where some had reportedly given their employees ultimatum in three days to quit the habit or lose their jobs. Others were simply sacked by their proprietors. *Proceedings of the Straits Settlements and Federated Malay States Annual Anti-Opium Conference.* p. 20.

As its status grew, the Anti-Opium Society in Singapore found it easier to rally support from other community organisations. Aside from the merchant leaders, social clubs and trade bodies were roped into the temperance cause. This included pugilistic societies, fish merchants unions, garden clubs and the Cinema Association. The more prominent group involved was the Women's Association which added the dimension of the family with the motto: "Elimination of Opium Habit begins with the Family."[72] Other than the local elite, the Society became the convergence point for regional and international temperance movements. Lending legitimacy to the foundation of the Anti-Opium Society was the visit to Malaya by the prominent British anti-opium campaigner and parliamentarian, Robert Laidlaw.[73] Aside from receiving their counterparts from the capital city, the abolitionists in Malaya also took their lobbying efforts to London to press the government directly for more commitment towards opium suppression.[74]

The members of the anti-opium societies also became the front men to receive visiting delegations by the various League of Nations opium commissions, particularly the prominent inquiry into the opium problem in the Far East in 1930. The impression made on this committee was evident in its report:

> The general view of the leaders of the [Chinese] community is that opium smoking is an anti-social vice, excessive indulgence in which detracts from the value of the individual. Chinese public opinion on the subject would express itself, if sufficiently strong, through various boards, committees and through the local press. At the time of the Commission's visit to Singapore, the Chinese community showed a very active interest in the opium question.[75]

Similar sentiments were also expressed in the Commissioners' visit to Kuala Lumpur where they found seemingly strong support for the anti-opium movement. The visit also provided an opportunity for some Chinese activists to claim "that they had all along

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[72] *N.Y.S.P.* 6 April 1934. Groups like the Women's Association expanded the platform of the Society in terms of publicity. On 6 October 1930, Chen Su Lan and Lim Kim Tian were invited by the Association to attend its annual conference at the Raffles Memorial Hall as guest speakers. Their speeches pertaining to educating families against opium smoking were widely reported in the media. *N.Y.S.P.* 6 October 1933.
[73] See: *S.T.* 20 December 1907.
[74] *S.T.* 1 October 1907.
[75] *League of Nations. Commission of Enquiry into the Control of Opium in the Far East,* Volume 2. pp. 85-6.

been agitating for the suppression of opium among their countrymen, but felt their efforts were hampered because they had not the co-operation of the government."[76]

With the support of the Chinese Consul at the point of its formation, the society subsequently hosted visiting Chinese officials and anti-opium counterparts to the Malayan Peninsula. Through the anti-opium societies in Malaya, the Chinese government discovered new networks to extend its influence with the Chinese disapora, especially on its negotiations with the Western nations regarding opium suppression. Since the operation of the Opium Advisory Council, China was routinely put under the spotlight for its negligence on suppressing poppy production within its own territories. By emphasising the number of Chinese opium addicts in European colonies, the Chinese representatives sought to perpetuate the image of their country as the helpless victim of vice.[77] A letter intercepted by the Colonial Office indicated the intentions of the Kuomintang to embark on a fact-finding mission in Malaya with the assistance of its overseas Chinese counterparts.

> The fact has been established that the policy of the Malayan governments is twofold, to attempt to destroy the real strength of the Overseas Chinese, and to increase [the state's] annual revenue. When the Malayan Governments definitely made the sale of opium a government monopoly, their action was inconsiderate and it has resulted in very great harm being done to the Chinese residents in Malaya. However our committee, in order to get facts which may be basis of future action has decided to send officials to Malaya to make an investigation, and obtain facts which will put us in a strong position in future in any matter that we take up and which will enable us to devise methods of rescuing Chinese residents in Malaya. As the territories under the control of the Malayan government are so extensive, clearly our investigators will not be able to visit every town. The help is solicited therefore of the Chinese Chamber of Commerce wherever there is one, and of other Chinese Overseas Associations, so as to ensure that the investigation shall not be a failure.[78]

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[76] Ibid. p. 117.
[77] For criticism of the opium monopolies of the colonial territories where Chinese migrant labour resided, see: Y.Lo. *The Opium Problem in the Far East* (Shanghai: The Commercial Press, 1933).
[78] Letter from Chiang Chi Kang, Opium Suppression Committee to Central Party Headquarters for the Kuomintang. 14 February. 1930 (Compilation of PRO records of the Kuomintang in Malaya, 1930-31 by the Central Library of the National University of Singapore. REF: SMC. DS596.3Act).

While their intention was to gain a greater appreciation of the situation in Malaya, these visitors also informed their local counterparts of the anti-opium movement in China.[79] As a result, such interactions fostered the impressions of commonalities facing both the Chinese disapora and their counterparts in the fatherland.[80] This was seen in the increased contacts between the Anti-Opium Society in Singapore with the Shanghai based National Anti-Opium Association,[81] through the annual conferences in Shanghai.[82]

Exposing the "Opium Smoking Devil"

A prominent inroad made by the Anti Opium Society was in the realm of publicity generated. Through countless articles in the English and Chinese newspapers as well as popular and medical journals, activists like Chen Su Lan, Lim Boon Keng and Wu Lien Teh sought to publicise the temperance message. These messages were commonly personified through the grotesque images of emaciated opium addicts devoid of any semblance of dignity. In one of his lectures, Dr Philip Tyau, the Chinese Consul General of Singapore described opium, as the source of all infectious diseases and social evils where:

Before becoming addicts to the drug they were diligent workers, devoted fathers and loving husbands, but no sooner has this vice got a grip on them than they neglect everything[...]their homes, their wives, children and work. They bring untold miseries on themselves and their families. Furthermore, when once this opium smoking habit is formed, deprivation of this narcotic brings along insomnia, bodily weakness, diarrhoea and nervous troubles. All these complaints vanish when the craving is satisfied. Again after

[79] For example, Mr Chen Hsi Hsiang from the Shanghai based National Anti Opium Society made several speeches in his visit to Malaya on the opium situation in China in addition of being briefed on the developments in the colony. *S.F.P.* 31 August 1931.

[80] For a more detailed discussion of the cultural networks, see: Mark Ravinder Frost. "Emporium in Imperio: Nanyang Networks and the Straits Chinese in Singapore, 1819-1914", *Journal of Southeast Asian Studies* 361(2005):29-66.

[81] According to the National Opium Association of China, among one of the three key problems of China's opium problem was the consumption of the narcotic by overseas Chinese. Hence it stated the "liberation of thousands upon thousands of Chinese labourers in the foreign powers' of far Eastern Colonies upon whose misery is founded on the enormous opium revenue" as one of its main objectives. It criticised the British government for amassing large profits from opium in the colonies of Hong Kong, Burma and Malaya and dismissed the regulations in these territories as being lax. See: The National Opium Association of China. *Opium: A World Problem*: (Shanghai Oct 1930). PRO/CO273/537/11: Social Hygiene.

[82] PRO/CO273/572/182049. "Monthly Review of Chinese Affairs." June 1931.

prolonged indulgence the mental powers become weakened and the moral faculties perverted. Then these habitués will commit any crime just to get the means to appease the craving. Rapidly the vitality of these slaves to the pipe begins to flag, their health runs low and their habits turn filthy. They neglect themselves. Being poor in bodily resistance, they contract diseases and in particular tuberculosis of the lungs. From now on and not until death, they are a burden to themselves and their families.[83]

Like Tyau, Chen Su Lan attributed the spread of tuberculosis, unhygienic personal habits, overcrowded and poorly ventilated living quarters with opium addiction. He contended the laxity with personal health, the symptoms of excessive coughing and spitting, and the shared use of opium pipes to be factors associated with the narcotic culture. This in turn provided apparently the medium for the transmission of the tuberculosis bacilli.[84] With the disease becoming a concern in the Malayan urban settlements by the 1920s, Chen's postulation would not have gone unnoticed. The medical practitioner subsequently launched an unreserved criticism of the status quo in his 1935 publication, *The Opium Problem in British Malaya.* Claiming that about ten percent of the population were addicts with anecdotal examples of lives wrecked by the habit, Chen lashed out against the reasons behind the apparent official tolerance of the narcotic culture.[85] Written in English, this booklet was aimed at not just at the authorities, but also to draw support from the European sections of the colonial society.

Lectures by campaigners, visits by foreign supporters, and official openings of opium societies and clinics were highly publicised events.[86] The first Opium Conference in 1907 witnessed huge crowds of ordinary people attracted not only by prominent community leaders. They became gala street festivals as well.[87] Aside from official events, the Society sought to spread the temperance message through theatre performances. It commissioned several Chinese operas with anti-opium themes such as "Opium-Smoking Devil", "The Wife of an Opium Smoker" and the "Most Poisonous Poison." Linking themes of opium indulgence with those of moral and national

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[83] *S.T.* 7 May 1934.
[84] *S.T.* 5 November 1931.
[85] Chen Su Lan. *The Opium Problem in British Malaya* (Singapore: The Singapore Anti-Opium Society).
[86] It was during the first year of the founding of the Anti-Opium Society that membership was at its highest. Between July to December 1907, the Society recorded an average of a thousand applications a month, before dropping to several hundred a month in 1908. *P.G.* 18 May 1908. The first anniversary of Chen Su Lan's Anti-Opium Clinic was also officially commemorated by the Chinese Consul General. About 10,000 refreshment tickets were issued and other entertainment activities being set up to mark the occassion. *S.F.P.* 14 May 1934.
[87] *T.M.* 8 March 1907.

depravity, these plays encouraged smokers to renounce their indulgence for the larger good of the nation.[88]

Reminders of the harmful effects of opium were also posted on huge slogans by the Society in cinemas, newspapers as well as on signboards in entertainment centres.[89] Apart from the public venues, efforts were also directed to organising debates and oratorical contests in schools to educate Chinese students on the virtues of abstinence.[90] With passions raised from dramatic statements and bold proclamations, these gatherings became emotionally charged affairs where narcotic addiction became spectacularised and carnivalised. A remarkable example in which an otherwise dull and inaudible speech by the British abolitionist Laidlaw in Penang was dramatised by the Chinese translators. Magnifying the campaigner's reputation, they were quick to infuse their own interpretations of his speech to fire the passions of the predominately Chinese audience. For example, Laidlaw's references to the potential of China to abolish the opium culture became transformed into an affirmation of the greatness of Chinese civilisation to the thunderous applause of the crowd.[91]

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[88] Yen Ching Hwang. "Chinese Revolutionary Propaganda Organisations in Singapore and Malaya, 1906-11", *Journal of South Seas Society*. 29:2 (Dec, 1974): 47-61. See also Tan. *The Anti-Opium Campaign in Pre-1942 Singapore*. p. 23.

[89] *N.Y.S.P.* 6 July 1937.

[90] For example, on 4 March 1933, the Society held its first oratorical contest entitled "Opium and Overseas Chinese at the Victoria Memorial Hall in Singapore in which a total of twelve schools participated. CO273/571/82049. "Monthly Review of Chinese Affairs." January 1933.

[91] *S.T.* 20 December 1907. While its graphic details were considerably sensational, the extrapolation of the potential evils of opium was treated with cynicism from certain circles, with counterproductive effects. In its report, the 1908 Opium Commission was reluctant to endorse the claims of the abolitionists as "The tendency for philanthropists to give undue prominence to such bad cases and to generalise the observation of them is undoubtedly a great factor in attributing to the use of opium more widely extended evils than really exist" *Straits Settlements and Federated Malay States Opium Commission, 1908*. p. 13

The Anti-Opium Clinic

One of the most prominent milestones of the Anti-Opium Society was the rehabilitative clinic. Prior to this setup, there were no government hospitals or medical facilities specifically devoted to opium addicts. The first calls for such wards came from Lim Boon Keng as early as 1898. In two articles written in the *Straits Chinese Magazine* and *Transactions of Straits Philosophy Society*, Lim urged the government to establish asylums to protect opium addicts and called for the Chinese community to provide financial support for this institution.[92] His ideas were realised with the financial support of the Chinese Consul-General in Singapore who offered his official premises for the refuge, which was formally opened on 23 May 1906.[93] A similar undertaking by Dr Wu Lien Teh came several months later on 7 November in Penang. The clinic distributed what it considered as free medicine to opium addicts, issued circulars and organised lectures several times a week.[94] While the clinic at the Chinese Consul's official residence received much public limelight, users saw it as another vagrant home and operations ceased shortly after the initial fervour.[95] The refuge was discontinued after a year in Singapore and Penang due to the absence of financial support to cover the monthly expenses of $600 a month.[96] The results also seemed to be dismal where three quarters of the 400 patients were found to have returned to their old habits upon discharge.[97]

The next concrete attempt was initiated by the colonial medical services at the urging of the anti-opium lobby. In 1924, the colonial medical services acceded to this request by Tan Cheng Lock, a member of the Legislative Council to establish special rehabilitative wards in the state hospitals for opium addicts.[98] In the Tan Tock Seng Hospital in

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[92] See: "The Attitude of the State towards the Opium Habit", *Straits Chinese Magazine* 2:6 (June 1898) pp. 47-54, and "Opium versus Alcohol", *Transactions of Straits Philosophy Society* 16:1 (July 1908) pp. 66-79. See also: "The Opium Smoking Habit and its Treatment", *The Journal of the Malayan Branch of the British Medical Association*. 1907 pp.83-91.

[93] The Anti-Opium Clinic was only part of the broader activities of the Chinese Consul in Malaya to promote pro-Manchu Nationalism in the region at a time where reformist and revolutionary elements were seeking political and financial support from the Chinese diaspora. Not only did it confer honourary imperial titles to local Chinese community leaders, but also aided in establishing a variety of literary and cultural societies. Yeh Ching Hwang. "Overseas Chinese Nationalism in Singapore and Malaya, 1877-1912", *Modern Asian Studies* 16:3 (1982): 397-425. pp. 409-416.

[94] Lim. *British Opium Policy in the Straits Settlements*. p. 29. Another attempt to involve the Tong Chee Hospital in setting up an anti-opium ward was unsuccessful. *S.F.P.* 14 May 1934.

[95] 1908 Opium Commission. p. C111

[96] Ibid. p. 30.

[97] *P.G.* 9 March 1908.

[98] *S.S.L.C.P.* 1924, p. B120.

Singapore, a ward was set up for this purpose.[99] Patients received at the hospital with symptoms of opium abuse were referred to it for further treatment. Admission and rehabilitation rates, however, fell short of the abolitionists' expectations.[100] Of 5,158 admitted between 1925-1929, about half, or 2,394, absconded, and 61 patients were expelled.[101] It was suspected the availability of free food and lodging offered by the opium ward was a primary cause of admission. This was particularly prevalent during the years of the Great Depression. As patients could not be forcibly detained, there was hence little incentive to complete the treatment in the restrictive hospital environment.[102] Last but not least, being unable to monitor the patients upon discharge, the anti-opium wards could not prevent them from resuming their habits. As a result, the rehabilitative centre was subsequently dissolved in 1933 after treating only 33 addicts for an entire year in 1932.[103]

Aware of these difficulties, Dr Chen Su Lan was nevertheless keen to sustain the momentum of the anti-opium efforts. As the prominent face of the campaign, the closure of the Anti-Opium wards would discourage rehabilitative efforts. It was under such circumstances that Chen decided to come out from private medical service to revive the institution. On 8 May 1933, Chen's Anti-Opium Clinic in Singapore started admitting its first patients. Learning from the experience of the Tan Tock Seng hospital,

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[99] PRO/CO273/551/5: "Proposals of Malayan government to League of Nations Opium Advisory Committee. 5 July 1928.

[100] The effectiveness of the rehabilitation centre was raised during the inquiry of the Opium Commission by a medical officer who had worked with the anti-opium wards. Of 699 patients with the opium habit enumerated, none's poor health conditions were attributable wholly to opium smoking. In respect of 295 patients, only in ten cases was indulgence in opium smoking put down as the principal cause of their unhealthy conditions. British Malaya Opium Committee: *Report of the Committee appointed 27 November 1923* (Singapore: Government printer 1924) p. A24. Another medical officer in the Durian Duan Hospital in Malacca also reported the difficulty in following up on the records of patients who went through the full course after a ward of about 30 beds was set aside for the anti-opium clinic. *Malacca Administrative Report*, 1925. p. 257-8.

[101] Ibid.

[102]. For the case of Malaya, the Commission noted the opium rehabilitation wards were "filled by coolies who came there to get the food and have a rest at the government's expense, or who wanted a temporary cure because they could not for the time being afford to smoke." League of Nations. *Commission of Enquiry into the Control of Opium Smoking in the Far East, Volume One* (Geneva, 1930) pp.31-2. Similarly, a report by Dr E.D. Lindow on a government commissioned pilot project on the treatment of Opium addicts in Singapore concluded that alcoholism was a more serious problem than opium, and that curing the habit would be insufficient without more holistic rehabilitation regime. *S.S.M.R.* 1925. "Appendix H: Report of the Treatment of Opium Habit". 5 March-31 December 1925. p.97. Riding on the publicity of the anti-opium clinic, pharmaceutical products with similar claims of curing opium addiction became more widespread even as they were frowned upon by medical profession . *S.T.* 21 December 1935.

[103]The Anti Opium Clinic (Singapore) *Opium is a deadly poison. An Interim Report* 8 May-Dec 1933 (deposited in the National university of Singapore, Central Library).

he devised a rehabilitation regime involving not just the gradual clinical application of opium substitutes. The patient was also required to openly pledge his commitment towards completing the treatment, and a guarantor to incur the costs should he abscond. To make their stay more pleasant, the Anti-Opium Clinic provided decent beds, clothing, slippers, three meals per day and recreational activities for patients. Those who were able to pay to defray the expenses were accorded with better facilities. During their confinement, patients were given instructions on "good personal habits of cleanliness entailing the regular brushing of teeth and baths, consumption of healthy meals and prevention of indiscriminate spitting."[104]

Carried by two doctors under the direction of Chen himself, the treatment process involved the "oral subcutaneous intravenous" and "infra muscular" administration of medicine.[105] The dosage was tailored according to the health conditions of the smokers. The treatment regime lasted about five days for healthy and light smokers to three weeks or longer for chronic cases. Following the first dosage, no medicine would be further given.[106] Chen also used the 605 Wassermann blood test on the patients to check for accompanying infectious diseases, particularly venereal diseases, which the clinic also treated simultaneously[107]. Within eight months of the opening of the clinic, the director reported about a thousand admissions with only less than forty expelled or absconded.[108] This news created a public sensation where the Consul General for China, Dr Philip Tyau reported on behalf of the clinic of 1,300 opium addicts cured within a year.[109] Nonetheless, Chen's Anti-Opium Clinic was forced to cease by August 1938

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[104]Ibid.
[105] Ibid.
[106] Ibid.
[107] Ibid.
[108] The Acting Director of the Medical Health Services in Singapore, R.D. Fitzgerald was asked to make inquires on Chen's rehabilitative practices. In his report, he expressed general satisfaction with the accommodation of the patients and their commitment to rehabilitation where upon absconding, patients or their guarantors would lose their deposits of up to $15. He was however doubtful of the degree of addiction of the patients, the effects of the treatment and incidences of relapses. Upon inspection, Fitzgerald concluded only one patient displayed symptoms of serious addictions while the rest were seemingly "moderate smokers." He was also disturbed with the generous administration of morphine by Chen to assist his patients in expelling the opium urge although the latter assured him this remained secret from his clients. After all, to Chen, these curative treatments were secondary to the "psychological" measures of moral suasion to get the patient to rid his addiction. Nevertheless, the official considered the absence of following up actions with discharged patients to be the most serious limitation of the clinic. PRO/CO882/18. No. 34034/34 [No.6]: "Report on the Anti-Opium Clinic," Singapore: R.D. Fitzgerald. Acting Director of Medical Health Services. 30 October 1934.
[109] *Singapore Free Press*. 7 May 1934.

apparently due to the diversion of public attention to the anti-Japanese war effort in China.[110]

Conclusion: "Changing the world around it"

In *Emperor of Dreams*, Mike Jay writes: "while opium did not change in itself, the world around it gradually did. The herb became a scapegoat in nationalistic fervour, a vector of racial anxieties, a pathogen in a professional struggle against self-medication and the very foundation of a new disease theory of addiction." [111] Mainstream historiography of opium have not critically questioned its addictive tendencies to be socially and historically determined. As such, the discourses of narcotics remains polarised between greed, profit and exploitation on one hand, and of the heroic crusades of abolitionists on the other.

The changing regard for opium in British Malaya demonstrates here the fluidity of the otherwise triumphant narrative of the march towards abolition of a "social evil". Since the 1820s, the opium culture in the colony was generally legally accepted. The economic displacement arising from the state's monopolisation of the opium trade, the growing trends of Chinese nationalism, and shifting international public opinion created the impetus for de-legitimising the drug. By the late 1930s, opium's popularity seemed to have decreased in Malaya. While restrictive policies could have been an attribute to falling consumption, the role of the anti-opium campaigners in stigmatising and criminalizing the culture within public consciousness should not be ruled out. Through the mass media, public speeches and lectures and official representations, the anti-opium campaigners dominated both the medical and moral high grounds in colonial society. In addition, the abolitionist messages were also significantly magnified in the highly spectacularised and carnivalised anti-opium public events. Part of the public limelight was the apparently successful pathologisation of opium and the proposition of its cures, which were further institutionalised in government hospitals and Anti-Opium Clinics.

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[110] Pung Eng Huat. *The Nature and Extent of Opium Addiction in Singapore and the Measures to Rehabilitate the Addict.*" (Honours Thesis: University of Malaya, Singapore: 1957) p. 103.
[111] Mike Jay. *Emperor of Dreams: Drugs in the 19th Century* (Sawtry: Daedlus, 2002) p.69.

The elevation of the opium habit from a popular indulgence to an alarming plague demanding individual abstinence and official discouragement reflected the influence of the non-European sector of colonial civil society. In the anti-opium campaigns, the ethnic Chinese activists in Malaya found a common bogey to unite the otherwise disparate community fractured along linguistic, regional groupings and clans. By equating opium with national decline, the anti-opium messages became one that called for solidarity with the emerging Republican China rather than their provincial identities. At a time when the colonial administration was concerned with what they felt as the infiltration of subversive activities from revolutionary Chinese political agents, the anti-opium campaign was generally tolerated.[112] Thus, these campaigners were able to negotiate through the Western dominated colonial civil society, the various legislative bodies as well as the clans and trade associations and newspapers of the Chinese community.

Compared to the merchant community, planters and the Rockefeller representatives, the anti-opium movement was probably most successful in mobilising public opinion across social strata for health. This will contrast, in the next chapter, with European women social hygiene campaigners who were pitted against a significantly less sympathetic public in Malaya.

[112] See: Yong C.F. *Chinese Leadership and Power in Colonial Singapore* (Singapore: Times Academic Press, 1992) pp.149-270.

Chapter 7
Taking their place in Public Affairs: Medical Missionaries and Abolitionists

Women are now beginning to take their place in public affairs. They are surgeons and physicians, lawyers, clerks, dentists and members of Parliament. Women are not going to be dragged in the mud and they have a right to be heard in these matters. [1]

From the *Singapore Diocese Magazine* on the medical missions

The abolition of these methods [of compulsory examination of prostitutes for venereal diseases] in the Far Eastern Crown Colonies is an important event in the history of human freedom and will mean a considerable improvement in human welfare and progress.[2]

Alison Neilans *The International Movement against Regulated Prostitution*

Introduction: "The Story of Man"

In his memoirs, Singapore's senior Statesman Lee Kuan Yew described the story of Singapore's progress as "part of the story of man's search for new fields to increase his wealth and well being."[3] Male personalities, European and Asian, have been in the foreground of Singapore's historical development and imagination. Comparatively, the historical narrative of the woman in colonial Malaya has been muted. As medical missionaries and abolitionists, this chapter features the roles of European women shaping the colony's public health infrastructure and politics, areas otherwise confined to men. Coming to Malaya independently from Britain, these women spearheaded the provision of maternal and infant health services. As activists, they were responsible for raising significant social consciousness on the politics of venereal diseases, particularly in the mandatory medical examination of prostitutes, enshrined in the Contagious Diseases Ordinance (CDO).

These activities were frequently carried out under the umbrella of several prominent organisations that were both concerned with, and operated within British Malaya. They included the Anglican based Medical Missions as well as the social hygiene groups like the British Social Hygiene Council (BSHC) and the Association for Moral and Social

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[1] *S.D.M.* 10 (34). February 1919. p. 20.

[2] The Women's Library (Henceforth known as WL) 3.AMS.61.6: Alison Neilans *The International Movement against Regulated Prostitution: Its Progress ,and Significance* (Revised April 1946)

[3] Lee Kuan Yew. *From Third World to First: The Singapore Story, 1965-2000.* p. 389. Lee noted that the New York based line editor of Harper Collins tried to make his memoirs "more politically gender correct", when wherever he wrote "man", he has become "person" or "people". In this respect, he thanked her "for making me appear less of a male chauvinist to Americans." Ibid. p. xix.

Hygiene (AMSH). Even as the retrieval of the voices of these European women is crucial in amplifying the narrative of the female gender in the colony, it is essential to contextualise their activities within the broader historiographical discussions. From opening dispensaries in the rural Malay heartlands to placing the CDO in the colony under international spotlight, the different layers of the activities of the European women in Malaya could be deciphered in several dimensions. In Chapter Six, ethnic Chinese counterparts deployed the rhetoric of opium addiction as a reflection of the general malaise to Chinese civilisation. Similarly, it will be seen how European ladies utilised maternal and social hygiene as means of linking reproductive health and sexual morality with the progress of medical science, the protection of women and the moral preservation of civilisation.

"No Useless Appendages": Women in Malayan Historiography

Historian Anne Witz observes the participation of white women doctors in the colonies remains a relatively neglected in both colonial and women's historiographies.[4] A more sustained historical insight into these woman practitioners and activists in turn provides a greater appreciation in which women have traditionally been represented as objects rather than subjects. As Cathy Lubeska states: "Women health issues are historically located in many different sites and the meanings of key terms such as "health", "illness", "women", "class" and "sexuality" are blurred, yet highly specific and gendered in their application."[5] This interest also represents part of the project of "refocusing the lens of history from the existing emphasis on men as the agents of history towards that of the women's experiences.[6]

[4] Anne Witz. "'Colonising Women': Female Medical Practice in Colonial India, 1880-1890" in Anne Hardy and Lawrence Conrad (eds). *Women and Modern Medicine* (Amsterdam, New York: Rodopi, 2001) p. 23.

[5] Cathy Lubeska. "Chasing Shadows: Issues in Researching Feminist Social Histories of Women's Health", in Ann M. Gallagher, Cathy Lubelska and Louise Ryan (eds). *Representing the Past: Women and History* (London: Longman, 2002) p.193.

[6] Nupur Chaudhuri and Margaret Strobel (eds). *Western Women and Imperialism: Complicity and Resistance* (USA: Indiana University Press, 1992) pp.5-6.

Nonetheless, their narratives should be more cautiously treated. As Clare Midgley warns:

> When scholars write women centred accounts of empire, which women are they putting at the centre? In seeking to rescue white women in the colonies from the derogatory stereotypes of male imperialists and imperial historians, are white women writers in danger of creating plucky feminist role models while ignoring their complicity in imperialism? [7]

As wives and daughters, the presence of white women in the non-Western world was thought to reinforce racial boundaries between the foreign and local societies through the creation of racially exclusionary domestic arenas.[8] In addition, while European female medical and social workers were able to gain access to the parts of the colonised societies, they still operated "within the colonial system that they benefited from the privileges that whiteness bestowed."[9] Given the complex position of the white woman's place in colonial history, the writing of her pasts becomes a dilemma between her continued silence and her reification.[10] In the case of sexual and reproductive health issues, Barbara Ramusack recognises that despite their ethnocentric biases and imperial ideals, European women activists served crucial political roles in the colonies. In particular, they kept the issues of women rights at the forefront of public discourse through lectures, polemical tracts, newspaper articles, monographs, surveys and personal memoirs to the publics of both the colonies and the metropole.[11] Aside from furnishing relevant public information, these campaigners were also responsible for providing the organisational frameworks for pushing for reforms.[12]

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[7] Clare Midgeley. "Feminist Historians and Challenges to Imperial History" in Gallagher, Lubelska and Ryan (eds). *Representing the Past: Women and History* p.89.

[8] Margaret Strobel. "Gender, Race, and Empire in 19th and 20th Century Africa and Asia", in Renate Bridenethal, Susan Stuard and Merry Wiesner (eds). *Becoming Visible: Women in European History* (Boston, New York: Houghton Mifflin, 1998) pp. 398-402. See also Indrani Sen. *Women and Empire: Representations in the Writings of British India* (New Delhi: Orient Longman, 2002) pp. 39-70.

[9] Clare Midgeley. "Feminist Historians and Challenges to Imperial History" in Gallagher, Lubelska and Ryan (eds). *Representing the Past: Women and History*. p.95.

[10] Jane Haggis. "White Women and Colonialism: Towards a Non-Recuperative History", in Clare Midgley (ed). *Gender and Imperialism* (Mancester and New York: Saint Martin Press, 1998) p.46.

[11] See: Jharna Gourlay. *Florence Nightingale and the Health of the Raj* (Aldershot: Burlington, Ashgate, 2003).

[12] Barbara Ramusack. "Cultural Missionaries, Maternal Imperialists, Feminist Allies: British Women Activists in India, 1865-1945", in Nupur Chaudhuri and Margaret Strobel (eds). *Western Women and Imperialism*. p.134. See also: Simon Dagut. "Gender, Colonial 'Women's History' and the Construction of Social Distance: Middle-Class British Women in Later 19th century South Africa" in *Journal of Southern African Studies*, 26(3), 2000: 555-72.

In a predominately male dominated historiography, the need to unearth the woman's voice and presence in British Malaya becomes necessary. While the presence of official records and other documents permits the portrayal of men as historical actors, the same materials have only represented their female counterparts as a statistical figure, a demographical trend, and a social problem.[13] Thus, the involvement of the medical missions and social hygiene movements in Malaya provides a crucial opportunity to present a more meaningful public role for women in the colony. As discussed earlier, the main contention lies with the difficulty of associating these mainly European women missionaries and abolitionist with either the ruling colonial elite or the subaltern masses.

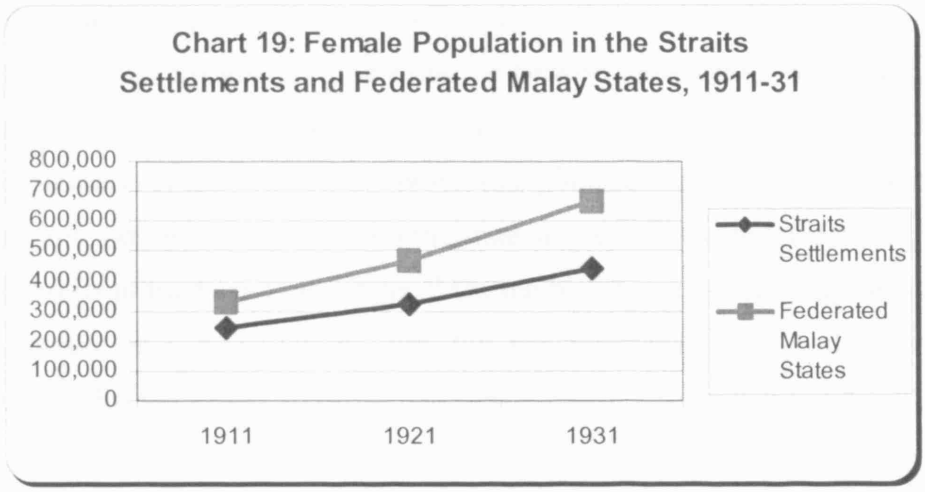
There has been a recent trickle of interest in the legacy of European women in Malaya. Consisting of 28 percent of the total European population in the colony by the 1920s, Margaret Shennan and Jean Teasdale stressed that these women were neither "just involved in frivolous social whirls" nor "useless appendages" of their husbands.[14] Even as they have managed to unearth the voices of several European women who had resided in the colony, Shennan's and Teasdale's treatments of these subjects remains generally anecdotal. Although emphasising their autonomies, both authors have also uncritically privileged their subjects' narratives above that of their non-European women in British Malaya. This view is also casually subscribed by Singaporean women writers who portrayed, "Progressive British laws and the efforts of Christian missionaries made possible the escape of mui tsai (Chinese servant girls) from oppressive institutions. The new freedom meant that they were now, finally, socially mobile."[15] Undergoing rapid socio-economic transformation, the bodies of the latter became central to the core issues of migration, demography, ethnicity, sexual and gender politics in the colony. Initially restricted, female migration to British Malaya was encouraged with the intention of rectifying an increasingly imbalanced and

[13] James Warren. "Prostitution in Singapore: Society and the Karayuki San", in Rimmer & Allen (eds). *The Underside of Malaysian History*. pp.166-7. A similar representation of women in Malaya only either as prostitutes or wives continues to be portrayed in Trocki's general review of Colonial Singapore. Trocki. *Singapore*. pp.62-6.

[14] Margaret Shennan. *Out in the Midday Sun: The British in Malaya*. (London: John Murray, 2000) p.192, and Jean Teasdale. *Facing the Bow: European Women in Colonial Malaya* (Australia: Uniprint, 1997) p. vii.

[15] Audrey Chin and Constance Singam. *Singapore Women Re-Presented* (Singapore: Landmark Books, 2004) p.14.

(therefore thought to be) potentially unstable male migrant population.[16] Census figures between two decades witnessed a considerable rise of one hundred percent as seen in Chart 19 below.



Source: *Census of British Malaya* for the years 1911, 1921 and 1931.

Following the migratory networks was the sex trade comprising of mainly Chinese and Japanese prostitutes. As the colonial authorities were increasingly preoccupied in dealing with migrant women, the significance of the role of domiciled and native women in Malaya became heightened by the late 19th century. The reproductive potentials of woman were being seen to be as crucial as the productive capacities of man in sustaining the territory's prosperity. This was evident in the 35 percent and 52.2 percent increase in the number of infants under five years of age in the Straits Settlements and the Federated Malay States respectively.[17] As such, the evolution and contestation of maternal and sexual health in British Malaya manifested the deeper anxieties in the regulation of the female body.

[16] Between 1871 and 1931, the census indicated the number of Chinese females in the Straits Settlements and the Federated Malay States rose from only 200 to 513 per 1,000 males. The population became more balanced only in the 1947 census. Sharon Lee. "Female Immigration and Labour in Colonial Malaya", *International Migration Review* 23(2), 1989, 309-331. p. 316.

[17] The number of children in the Straits Settlement registered a rise from 55,528 in 1921 to 75,324 and 86,152 to 131,099 in the Federated Malay States. *Census of British Malaya, 1921*. p.62.

Despite their marginal social position, considerable attention has been given to the study of women's health in colonial Malaya. Aside from works on institutional histories of medical institutions as well as Manderson's focus on reproductive and infant health, an overwhelming proportion of scholarly interests have been devoted to sexual politics.[18] This pertains mainly to the relationship between prostitution, venereal diseases and the controversies of the implementation of the Contagious Disease Ordinance. The exploration of this relationship provides a glimpse of not only the colonial public health regime, but internal rifts within the state and tensions with local society from business interests to triads and prostitutes.[19] On the broader scale, this emphasis places venereal diseases as "an important site for the intersection of medicine, sexuality and imperialism."[20]

Ironically, with a heavy reliance on official records, the narrative has become almost completely dominated by the perspective of the male European colonial

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[18] For institutional histories see,: Tan Kok Hian and Tay Eng Hseon (eds). *The History of Obstetrics & Gynaecology in Singapore* (Singapore : Obstetrical & Gynaecological Society of Singapore, and National Heritage Board, 2003). For Manderson's works on reproductive health, see: *Sickness and the State.* pp. 201-299, and "Women and the state : Maternal and Child Welfare in colonial Malaya, 1900-1940", in The Wellcome Institute series in the history of medicine. *Women and Children First: International Maternal and Infant Welfare, 1870-1945* (London: The Wellcome Institute, 1992) pp. 154-77, and, "Blame, Responsibility and Remedial Action : Death, Disease and the Infant in Early 20th Century Malaya", Norman Owen (ed). *Death and Disease in Southeast Asia. 257-282.* For pre-war writings on maternal Health, see: S.C. Yin. "Infant Mortality" *Straits Chinese Magazine* 11.2 (December 1901) pp. 145-7, and J.Galloway. "The Care of Children in the Topics", *Straits Chinese Magazine.* 11.2 (December 1901. pp.48-57.

[19] See: Manderson. "Colonial Desires: Sexuality, Race, and Gender in British Malaya", *Journal of the History of Sexuality* Vol.7, No. 3 (Jan 1997). pp. 372-88, *Sickness and the State.* pp.166-201, Tan Beng Hui. "Controlling Women's Bodies: The use of Women and Girls Protection Legislation in Colonial Malaya (1860s-1940s) in Mohammad Hazim Shah, K.S. Jomo and Phua Kai Lit (eds). *New Perspective in Malaysian Studies* (Malaysia: Malaysian Social Science Association, 2002). pp. 54-83. Philippa Levine. "Modernity, Medicine, and Colonialism : The Contagious Diseases Ordinances in Hong Kong and the Straits Settlements", in *Positions* Vol.6, No.31 (1998): 675-705. James Warren. *Ah Ku and Karayuki San: Prostitution in Singapore,1870-1940* (Singapore: Oxford University Press, 1993) pp. 100-122. Sharon Lee. "Female Immigration and Labour in Colonial Malaya.", *International Migration Review* 23(2), 1989. pp.317-9. Rosemary Kemp. "An Investigation into the Social Hygiene Problem in Singapore during the 1920s", *Journal of South Seas Society.* Vol 51 (1996): 51-126. Brenda S. Yeoh. "Sexually Transmitted Diseases in late nineteenth-and twentieth-century Singapore", Lewis, Bamber and Waugh (eds). *Sex Disease and Society* (Westport, London, Greenwood Press, 1997), Ng Siew Yong. "The Chinese Protectorate in Singapore", *Journal of Southeast Asian History*, Vol.2. 1961. pp. 76-97, Eunice Thio. "The Singapore Chinese Protectorate: Events and Conditions leading to its Establishement, 1823-1877." *Journal of the South Seas Society* 6(1/2):40-80, 1960.

[20] Roger Davidson and Lesley A. Hall (eds). *Sex, Sin and Suffering :Venereal Disease and European Society since 1870* (London, New York: 2001) p. 11.

administrators.[21] The prostitutes at whom these measures were directed, became mere spectators of the policy disputes between the governors and the Colonial Office in London. While there has been some mention of the social hygiene movement or non-state players, they have either been given passing reference or insufficiently theorised.[22] Similarly, in the midst of describing the expansion of state maternal and infant healthcare in Malaya, the agencies of women as medical workers and patients have been sidestepped. Given the scarcity of primary accounts of women in colonial Malaya, the experiences of the European medical missionaries and temperance movements become crucial in bringing them closer to the historiographical fashion concerning the female gender in the colony.

"Work for Christ in the most scientific manner"

While the Anglican Church was established in Malaya during early 1830s, medical missions with the Singapore Diocese did not take place until the 1910s.[23] From rudimentary clinics in both the rural heartlands of Malacca and the urban slums of downtown Singapore, the medical missions made substantial inroads into the development of maternal and infant health services in the British colony. In 1911, the first medical mission, a basic hospital, was established in the Jasin rural district of Malacca and was headed Dr Mildred Staley, previously a medical officer in Stephen's Hospital in Delhi.[24] This was followed by a similar medical centre cum outdoor dispensary in Bencoolen Street in the municipal area of Singapore on 18 October 1913.[25] Subsequently another two dispensaries were opened on 1 February 1914 in Upper Cross Street in the ethnic Chinese quarters and the other suburban area of Pasir Panjang (populated mainly by Malays) in 1915.[26] Meanwhile, plans were being drawn

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[21] A recent attempt to recover the prostitutes' voices in history can be seen in Haryati Hasan's "Malay Women and Prostitution in Kota Baru, Kelantan, 1950-70, *Journal of the Malaysian Branch of the Royal Asiatic Society*, Vol.78, Part 1, No.288 (June 2005): 97-120.

[22] Only Warren, Hylam and Kemp provided passing reference to the responses of community groups in the discussions over the CDO and prostitution in the colony in general. See: Warren: *Ah Ku and Karayuki San*, pp. 122-155, and Kemp, "An Investigation into the Social Hygiene Problem in Singapore during the 1920s", *Journal of South Seas Society*, p. 106-110. Ronald Hyam, *Empire and sexuality; The British experience*, (Manchester and New York: Manchester University Press, 1990), p. 152.

[23] For the activities of the Anglican Church, see: Loh Keng Aun, *Fifty Years of the Anglican Church in Singapore Island* (National University of Singapore: Department of History, 1963).

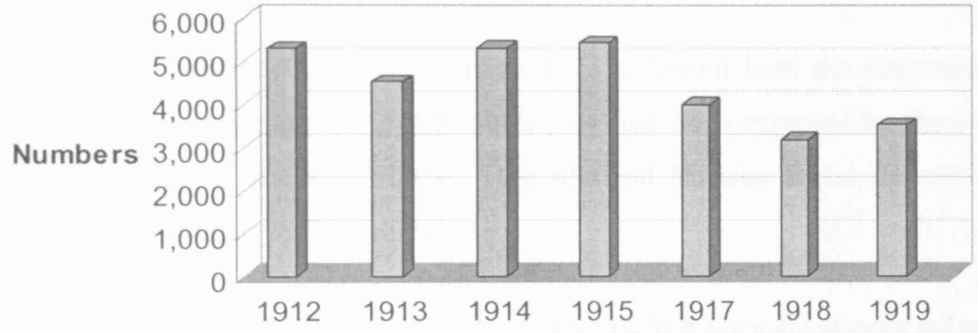
[24] *P.G.* 5 October 1911.

[25] The neighbouring rubber plantations had also provided financial support to the building of the dispensaries. *S.D.M.* 3(13), February, 1913, p.45.

[26] The mission at Cross Street was subsequently moved to New Bridge Road as the building premises were slated for demolition to pave for new houses. The Pasir Panjang dispensary operated until 1919

up for a more permanent presence in both Singapore and Malacca. As shown in Chart 20 below, the medical mission was becoming increasingly popular with an average of 3,000-5,000 attendances a year. Apart from its main purpose of treating gynaecological related diseases, the missionaries also performed minor and major surgeries, dental extractions, as well as treating endemic problems and performing vaccinations (see Table 29 in Appendix 6 of Annex A for details).

Chart 20: Attendances at Medical Mission, 1912-1919



Source: *S.S.M.R.*1912-1921 (Note: data for 1916 is missing).

On 22 May 1923, the mission officially opened the Saint Andrew's Mission Hospital in Singapore. Following closely behind was the establishment of the Saint Nicholas Home for the Blind in Malacca on 10 September 1926 to cater to the increasing number of visually impaired children. [27] By 1939, the medical mission had expanded out of the traditional boundaries of maternal health to include an Orthopaedic section.[28]

On top of the chronological milestones, the institutional evolution of the maternal health services of the medical mission must be situated in the context of British colonialism. Several contrasting themes would be posed there on the double roles of Western medicine and Christian evangelism in not only the areas of the expansion of modern

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where it was closed due to the shortage of staff. Loh. *Fifty Years of the Anglican Church in Singapore.* p.33

[27] *Pinang Gazette and Straits Chronicle*. 21 March 1932.

[28] For details of the chronological development of the maternal medical mission and the St. Andrew Mission Hospital, see: Loh. *Fifty Years of the Anglican Church in Singapore*. pp. 32-42.

maternal healthcare against traditional indigenous practices. In appearance, the medical missions seemed to have combined Christian charity with modern medicine. The medical health initiatives of the European women ran parallel with the plans of the colonial medical services in developing its maternal and infant health infrastructure. In fact, during the 1910s, the colonial authorities relied on the medical mission for the training and certification of midwives according to what the mission thought of as modern standards.[29] As such, it could be argued that the church became another tentacle in the spread of colonial public health into the domestic realm and the displacement of folk practices in colonial Malaya.

However, it would also be more appropriate here to layout both the constraints and contributions of the missionaries.[30] Although they had been expected by the colonial media to spread the message of Christ,[31] the Medical Mission stated the priority of healing the body over that of the soul where:

> [...]to preach the life of Christ by deeds by following his example by doing works of mercy and unselfish service for others. The future could be left with God, if we were in such practical ways living out Christ's life. Women hospitals were necessary in the East if women were to enjoy the benefits of Western skill and science.[32]

The women medical missionaries also seemed to be aware of the potential theological pitfalls in the tendency of exploiting the medical sciences to preach the gospel. In the comments of Dr Elise Warren: "As the general principles of the work are still apt to be misunderstood, it may be well to state that the medical work is not a bribe or sort of big drum to attract crowds to listen to the preaching."[33] Another reason that seemed to have limited the evangelical zeal was the language barrier, which "makes it impossible for us

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[29] St Andrew's Mission Hospital. *Annual Report*. 1957.p.1 (St Andrew Community Hospital, Singapore).
[30] For a more detailed discussion of this issue, see: Rosemary Fitzgerald. "Clinical Christianity: The Emergence of Medical Work as a Missionary Strategy in Colonial India, 1800-1914", Buswamoy Pati and Mark Harrison (eds). *Health Medicine and Empire: Perspectives on Colonial India* (Hyderbad: Orient Longman, 2001) pp.88-136.
[31] Commending the work of the medical mission, the *Penang Gazette* "believed that a medical mission has a very special power of interpreting the Christian message to those who do not understand our faith, and to every Christian the works of mercy, which are the necessary accompaniment of a medical mission." *P.G.* 11 December 1911.
[32] *S.D.M.* 1(2). February 1911. p. 7.
[33] *S.D.M.* 8(29) November 1917. p. 48.

to give all our patients the most precious thing we have, the knowledge of the Gospel."[34]

"Only a woman like us"

Moreover, the charge of the extension of colonial control through the replacement of traditional medical practices with a Western biomedical culture was basically an ideal rather than outcome. While expressing in principle support for increasing state intervention in maternal and infant health, the medical missionaries believed compulsion alone would only be of limited success. Quoting from the *Journal of the Association of Medical Women in India,* the editor of the *Singapore Diocese Magazine* felt a similar context faced by the Medical Mission in Malacca and Singapore where: "Until such public opinion is formed, the efforts of the paternal government to check the evils that abound in indigenous midwifery customs are about as futile as the efforts of Miss Partington with her broom against the Atlantic Ocean."[35] To change mindsets however required the trust of the villagers that the missions were directed. In the Malacca branch, the free services of the dispensaries and clinics were popularly received. House calls were also regularly made, which provided a crucial opportunity for European woman to obtain greater access into the domestic realm. Dr Mildred Staley for one sought the use of modern biomedical instruments to underline the importance of public health to her patients where: "With the help of a microscope they see the germs of preventable diseases that at present cause so much suffering and loss of life."[36]

From the accounts of the medical missionaries, their clients were intrigued by the medicines and treatments offered. To some extent, this novelty elevated the popularity of these otherwise peculiar white women doctors. Dr Warren recounted the commonly excited reactions by Malay villagers upon her routine visits to the surrounding areas screaming: "Bring out your sick. The white medicine ladies from Malacca have arrived. They have plenty of fever mixtures today and their skin cures are very good. They have things for pulling out teeth, but they cannot wait for many hours. Fetch the sick people

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[34] *S.D.M.*, 5(19), May 1915. p. 42.
[35] *S.D.M.* 5(17) November 1914. p. 25.
[36] *S.D.M.* (12), August 1913. pp. 30-31.

quickly." [37] Nonetheless, the popularity created heightened expectations of the presumably miraculous cures. As recalled by Warren: "The friends of a suffering woman heard that we had a wonderful gas with which we could put people to death, get rid of their tumours or other causes of pain, and then gradually let the dead return to life! Exaggerated accounts of our skills have reached the surrounding kampongs."[38]

Again, it was the word of mouth that the medical missions had to rely on, particularly in the area of surgery, an alien concept to the villagers. The initial fear of the knife was gradually abated as more women underwent different types of mostly minor surgeries. As the number of operations became less infrequent, the local women became more inclined to undertake the process having heard positive accounts from other patients. Dr. Warren acknowledged: "Without the help of old patients, we should often find it difficult to persuade new ones to undergo surgical treatment. This is the sort of thing we hear Malay women saying to each other-"The white doctor is not a ghost, so do not be afraid." She is not a rich man, but only a woman like us, so do not be shy."[39]

Without a more familiar environment in which drugs and surgeries were applied, the introduction of Western methods of treatment would not be widely received. The communitarian nature of the early years of the hospital stood in contrast with the notions of a clinicalised modern hospital. Interpreting such a phenomenon to represent the backwardness of the rural Malays, the missionary doctors often complained of how their works were frequently disrupted by well-intentioned patients and their visitors eager to provide assistance or make enquires about fellow patients.[40] The Western women doctors had also to contend initially with not just their patients consulting a variety of Malay, Chinese and Indian healers who were occasionally seen in the mission hospital. As Dr Warren noted, it was common for example for "Chinese women [who] wish to combine their own methods of treatment with ours (when it was found on one occasion a pearl had been crushed up and forced inside the scalp wound of an infant].[41] In fact, she even complained about "experienced patients" offering their own diagnosis to newcomers in the hospital. Dr Warren also observed: "They point to the sort of

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[37] *S.D.M.* 4(14) February 1914. p.47.
[38] *S.D.M.* 3 (12), August 1913. p. 31.
[39] *S.D.M.*. 5(20) Aug 1915. p.60.
[40] *S.D.M.* 3(11) May 1913. p. 42.
[41] *S.D.M.* 4(14) February 1914. p. 48.

medicine that suits them best, screaming out that all others are very nasty. Often, they insist that the doctor shall feel their pulse before examining the teeth or obvious cause of malaise."[42] Furthermore, responding to the overcrowding arising from relatives insisting on staying with patients, the medical mission had to enlarge its premises to accommodate more visitors.[43] The biggest difficulty it seemed, was the exaggerated expectations of Western medicine, leading patients to express greater interests in cures rather prevention. As Dr Warren reported: "No babies dying with tetanus have been brought to us lately. We fear this is merely because the women have found out that we cannot cure such cases and not because all have learnt to prevent catastrophes of the sort."[44]

Of the measures, Dr Staley found home visits to be the most effective means of propagating public health education. Reporting several months after the opening of the first medical mission, she commented:

> Visits to the kampongs, where one spends several hours, sitting and talking with the women quietly in their own houses are very valuable and give splendid opportunities for teaching on health and other matters. One is continually surprised at the number of sick who are grateful for European treatment and medicines, which as a rule are faithfully drunk and the directions obeyed.[45]

Persuading local society towards improving the social conditions of their womenfolk seemed to be a more uphill task for the medical missionaries. In the dispensaries in rural Malacca at least, the provision of maternal health services gave the Western female missionary doctors a certain amount of respect and influence. In particular, they seemed concerned with the plight of many Malay women they saw who had not only little knowledge of maternal and infant health, but seemed to live under apparently oppressive family structures. Dr. Warren for one related a graphic incident of trying in vain to obtain a fairer arrangement for a Malay woman called Fatima. A mother of six children (four who died at birth), Fatima faced estrangement from her husband who had exhausted the family property to obtain a new wife.[46] With such experiences, it seemed that the medical missionaries were probably more successful in propagating the

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[42] *S.D.M.* 4(14). February 1914. p. 47.
[43] *S.D.M.* 4(14) February 1914. p. 48.
[44] *S.D.M.* 3(13) Nov. 1913. p. 45.
[45] *S.D.M.* 1(4) August 1911. p. 3
[46] *S.D.M.* 6(21). November 1915. p. 12

principles of their study of Western maternal health than challenging what they regarded as the more entrenched local patriarchal structures. In fact, Warren's accounts had probably reinforced the racially stereotypical notions of the backward, pre-modern Malay society that required the enlightenment of the West.

"They must Increase and We must Decrease"

Where their influences over the households were apparently limited, the medical missions had greater success in making women more publicly visible. This came at two levels, the recruitment of non-European women into the nursing staff, and spurning further community participation in maternal health work. Since it commenced operations, one of the main priorities of the mission was to develop the local nursing profession. To Dr Staley, the absence of local nursing staff was the source of the maternal health problems where:

"Many women with scant knowledge and little or no training have in places done nobly what they could to help their sisters, who prefer dying to being attended by a man doctor[47][...]We are anxious to get the daughters of such women educated to take their place[of traditional midwives] and we hope that before many more generations have passed, death from blood-poisoning will no longer be looked on as inevitable in a large number of cases.[48]

In Dr Warren's opinion of the continuity of the mission: "If our work is to be permanent, our Asiatic helpers must shoulder the burden and be placed in positions of responsibility after passing the government examinations. Our motto must be in the connexion, 'they must increase and we must decrease.'"[49] As such, the medical missionaries devoted time for the training of nurses according to government standards. In the Malaccan clinic: "Visitors[...]on Wednesday or Saturday mornings realise that this is now more like a school than a hospital on those days. For patients are warned that all but urgent cases will be asked to go away or wait while midwives and pupil nurses from far and near are welcomed and taught."[50]

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[47] *S.D.M* 1(2) February 1911. p.6
[48] *S.D.M.* 4(21) November 1915. p. 50.
[49] *S.D,M* 8(29). Nov 1917 p.29.
[50] *S.D,M.* Vol.3 (12). August 1913.pp.30-31.

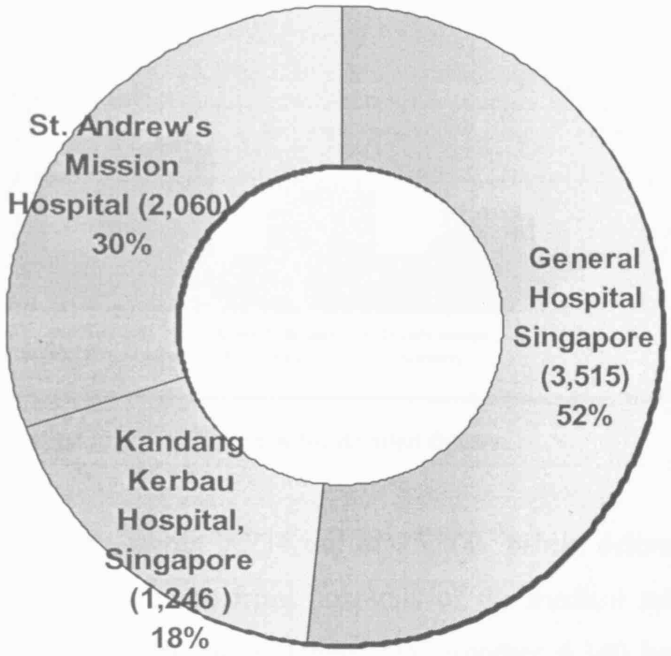
To the women medical missionaries, a considerable obstacle to surmount was the generally low priority placed on women's education in the colony, which would hinder them from pursuing higher medical studies. Dr Warren commented that without proper educational foundations, it was unlike that the local women would be able to be trained as "first rate medical missionaries."[51] As Dr Staley observed:

> We hear from other lands of medical missionaries who hope they will only be needed for a few years as they are training such excellent Asiatic workers to take their places. And we met Malay women who make capital nurses in their own villages and soon learn how to prevent causing their patients unnecessary suffering. But they are shy and illiterate and can hardly be expected to go to Singapore or abroad to qualify as surgeons. So it seems that for many years to come in this part of the world foreign medical women will be needed to treat Moslem mothers and children.[52]

Nonetheless, in retrospect, the medical mission contributed to not just the expansion of the nursing and midwifery in the colonial medical services. More importantly, they were instrumental in helping open the local public health infrastructure to local women patients who previously felt discomfort in a male dominated environment.

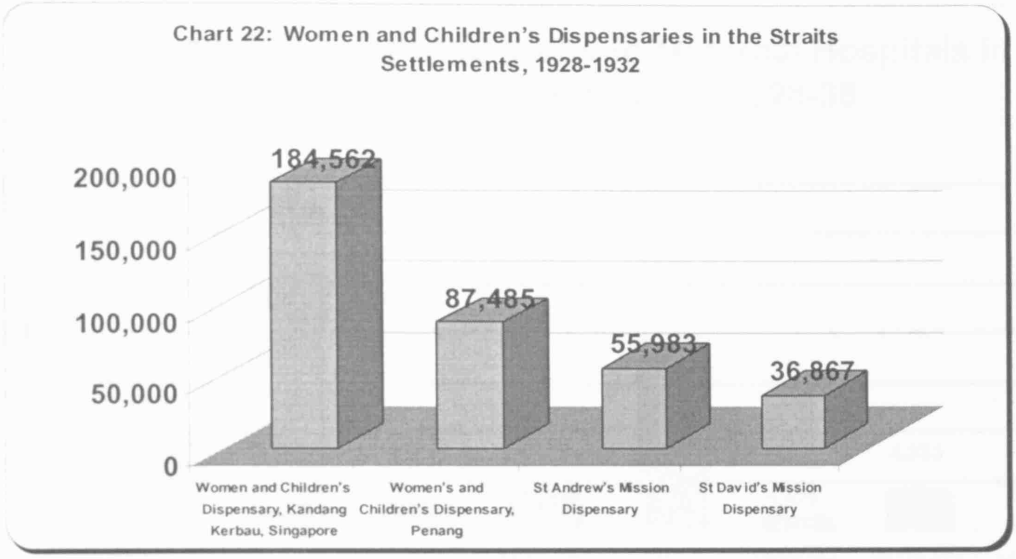
[51] *S.D.M.* 8(6). Feb 1917. .42
[52] *S.D.M.* 3(13) November. 1913 No 13. p. 45.

Chart 21: Child Admissions into Singapore Hospitals, 1928-32



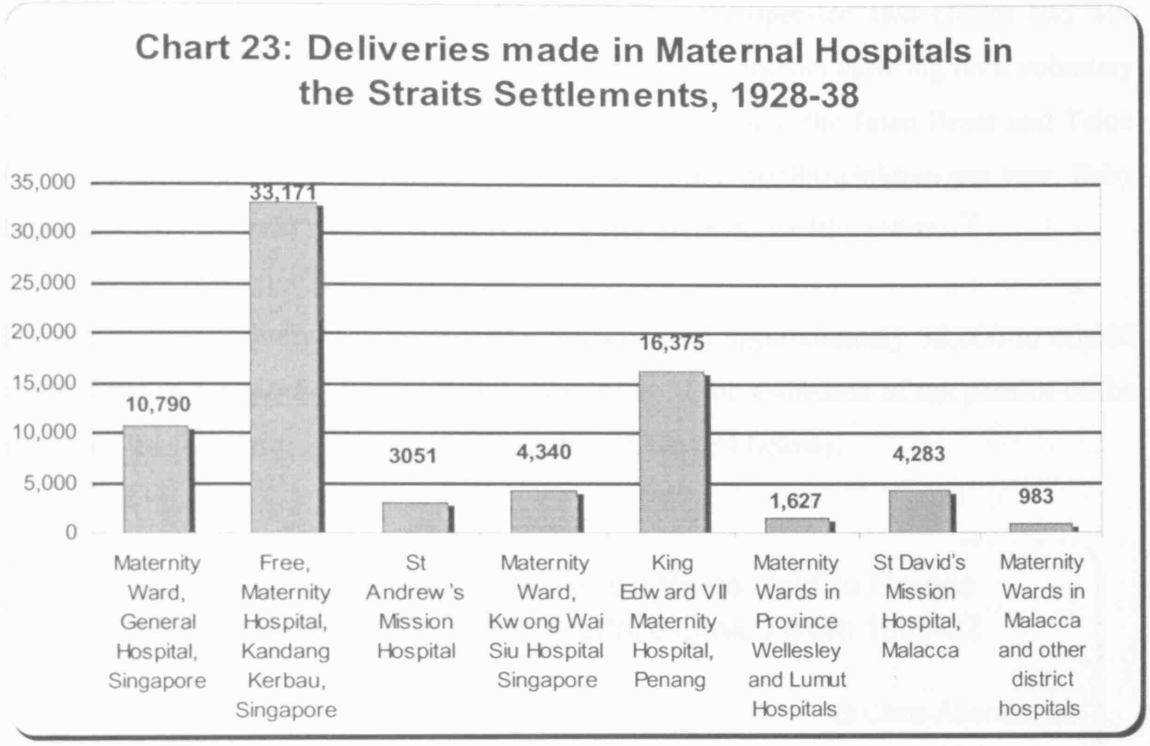
Source: *SSAR,* 1928-32. Note: See Table 30 in Appendix 6 of Annex A for detailed admission rates.

As seen in Chart 21 above, the Children Ward of Saint Andrew Mission Hospital served about one third of the total hospital admission of an annual average of 1,500 children in Singapore by the late 1920s. Similarly the dispensaries of the maternal missions recorded about twenty five to thirty percent of the total of about 75,000-90,0000 female and child patients in the Straits Settlements (see: Chart 22 below).



Source: *S.S.A.R.* See Table 31 in Appendix 6 of Annex A for detailed figures.

In the area of reproductive health, about 7,734 out of 75,000 babies delivered in the hospitals of the Straits Settlements came from hospitals of the medical missions (St Andrew's and St David's Mission Hospital (Chart 23). Another 4,340 babies were delivered in the Kwong Wai Siu Hospital. Together with the mission hospitals, these meant that about one out of seven hospital births took place outside the main government medical centres. Added to this, through these hospitals, greater employment opportunities were offered to Asian women as nurses and midwives in the public health sector.



Source: *SSAR*, 1928-38. Note: see Table 32 in Appendix 6 of Annex A for more detailed figures.

Last but not least, the activities medical mission opened up greater avenues for the participation of both European and Asian women in the otherwise male dominated colonial civil society. Comprising mostly of wives of prominent administrators or merchants, this group was instrumental in supporting the mission's development through logistical and financial means. The significance of the missions as a women-driven undertaking was symbolically brought to the forefront by the support giving by the wives of the British Governors in the colony.[53]

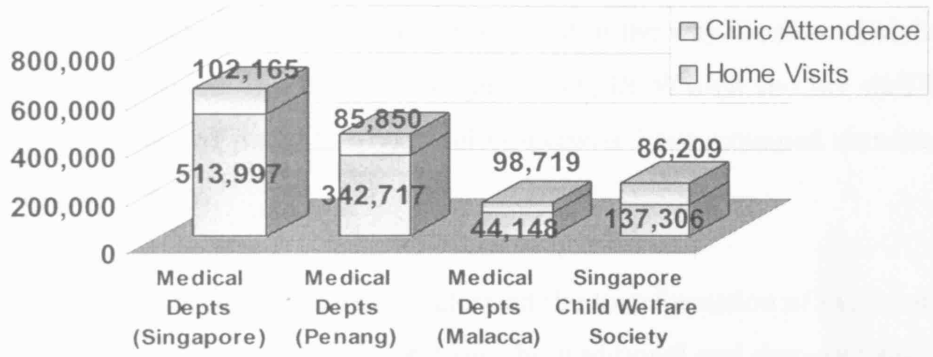
Acting through either organisations like the Chinese Ladies Association and the Church Workers Association, or as individuals, these women also donated equipment and clothing to the hospital in addition to organising educational and recreational activities for especially child patients.[54] The enlarged public space opened by the medical missionaries seemed to have inspired similar women based maternal health work. Just as the St. Andrew Mission Hospital was expanding in Singapore during the 1920s, a

[53] *S.D.M.* 3(5), November 1911. p. 19.
[54] Saint Andrew's Mission Hospital. *Annual Report, 1940.* p.8. Among one of the more outstanding supporter of maternal health services was Mrs Lee Choon Guan, daughter of a prominent Chinese merchant. She was among the first to give scholarship to Chinese women for training in modern nursing and midwifery. Song. *One Hundred Years of the Chinese in Singapore.* p. 541

Child Welfare Society began to surface. The Society operated two clinics and was staffed by two matrons, four health visitors and several doctors assisting on a voluntary basis. With about $5,000 raised by the Chinese community, the Jalan Besar and Telok Ayer clinics were attended by about 7,000 mothers and 16,000 children per year. Baby contests were also held with $800 worth of prizes given to healthy infants.[55]

In spite of its relatively tiny set up, the Society paid approximately 30,000 to 40,000 home visits in Singapore, a substantial proportion of the estimated of ten percent of the total sum for the entire Straits Settlements (see: Chart 24 below).

Chart 24: Combined Returns on Visits Paid to Homes and Attendances in Child Welfare clinics from 1928-32



Source:*S.S.M.R*, 1928-32.

Concurrently, there were other Chinese based community organisations like the Kwong Wai Shiu Hospital and the Kuala Lumpur Maternal Association that were taking an increasing interest in maternal and infant health.[56] As seen in Chart 23, the former, based in Singapore also took a visible proportion of the share of maternal health admissions in the colony. Similarly, generously funded by Chinese community

[55] Records pertaining to the Child Welfare Society do not seem to be available. The Society was mentioned in the Straits Settlements medical records during the 1920s for its contribution to maternal health provision in the colony . By the early 1930s, it seemed to have faded into oblivion. See: *S.S.A.R*, 1927, p. 25, and 1928, p. 28.

[56] Kwong Wai Shiu was established in 1910 by a group of Cantonese merchants with the intention of providing free hospital services for Cantonese immigrants to Singapore.

organisations, the Kuala Lumpur Maternal Association took the burden of catering to an average of 1,5000 admissions and 1,000 deliveries of babies a year.[57]

Observing the historiography of reproductive health in India, Sarah Hodges commented: "clearly, attempts to medicalise childbirth cannot be understood as simply an effect of improved clinical outcomes, but rather we must also investigate this history in terms of how new practices were imbued with positive social, political and cultural values."[58]Given its extensive and multi-layered influence, the medical missions here should not be viewed merely in the lens of "maternal imperialism" or "civilising missions" Even as these intentions were being expressed, they became secondary to the avenues for the participation of women in colonial civil society through the use of modern biomedicine. The provision of health services gave the medical missionaries access to the rural and even domestic realms of local and immigrant families. As the colonial administration acknowledged: "Working in out of the way districts of Malacca, miles away from government hospitals and dispensaries, Dr Warren and her staff have been able to reach a class of patients who would otherwise have remained untreated or under native treatment only."[59]

In the process, the medical missions had accelerated the transformation of maternal and infant health, particularly that of childbirth from the traditional and domestic realm to the institutionalised and modern public arena.[60] While these women had pioneered and supplemented the development of the maternal health infrastructure, the next section focuses on another group who made their mark through more contentious advocacy.

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[57] Not much has been known of the Association aside from the only annual report published in the *Malay Mail* that indicated it had been providing maternal health services since 1921. The Association had received generous donations of about $21,000 from Chinese philanthropists like Loke Yew as well as cultural bodies like Thong Look She Theatrical Syndicate and Chui Lok Amateur Drama Association in addition to a monthly grant of $200 from the Selangor Government. *M.M.* 15 April 1926.

[58] Sarah Hodges. "Towards a New History of Reproduction in Modern India", Sarah Hodges (eds). *Reproductive Health in India: History, Politics, Controversies* (New Delhi: Orient Longman, 2006) p. 5

[59] *S.S.A.R.* 1914 (Malacca). p. 74

[60] Alison Bashford describes this transformation as part of the larger project of modernity in the reshaping of maternal institutions and experiences, particularly in non-European societies since the late nineteenth century. "Medicine, Gender and Empire", in Philippa Levine(ed). *Gender & Empire* (USA: Oxford University Press, 2004) pp. 125-6

"The Woman we touch because she is in our power"

In the area of sexual health, high rates of venereal diseases were already registered in British Malaya during the 19th century. Blame was however attributed to the prevalence of prostitution among the immigrant Chinese population in especially the urban centres of the colony. On a conservative estimate, the number of brothels and prostitutes in the colony were estimated to be about 800 and 3,000 respectively, concentratied mainly in Penang and Singapore.[61] The relatively small colonial administrative apparatus had little means in policing brothel prostitution controlled by secret society elements.[62] To the authorities, the practice of compulsory medical examination of prostitutes for venereal diseases was one of the only means of having access to these closely watched women.[63]

Doubts were expressed about the effectiveness of these in either the regulation of public health or the protection of women.[64] Nonetheless, by 1860, the practices accompanying the CDO were prevalent not just in Britain, but also its colonies. These legislations corresponded with the rise of women's groups increasingly making use of the politics of venereal diseases to platform their agendas. Fronted by British moral campaigner Josephine Butler, they were organised in opposition to the humiliating medical examination of women required by the Ordinance.[65] Broadly regarded as the social hygiene movement, the arguments attracted significant support across political spectrums. Middle-class women concerned with implications for sexual morality and

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[61] According to the League of Nations, there were about 2,200 prostitutes registered in known brothels in Singapore with about 895 women from China arriving in the colony to be involved in the vice trade. Within the Federated Malay States, there were about 227 brothels with 1,500 prostitutes, mostly Chinese whereas the numbers amounted to an average of 44 brothels and 522 girls during the 1920s. See: League of Nations. *Commission of Enquiry into Traffic in Women and Children in the Far East, 1932.* pp. 53, 289, 296. For further discussion on the estimation of prostitutes, see: Lai Ah Eng. *Peasants, Proletariat and Prostitutes* (Singapore: Institute of Southeast Asian Studies Research Notes and Discussion Paper, 1986) No. 59 and Lim. J. "Social Problems of Chinese Female Immigrants in Malaya, 1925-40", *Malaysia in History*. 23:101-109.

[62] Justifying the measures of mandatory medical examination of prostitutes in Singapore and Hong Kong, the Secretary of State for the Colonies argued in 1856: "I think that the houses of ill fame and their inmates should be registered and subjected to police regulations, in the first instance of a sanitary character, that a strict weekly inspection should be enforced and that all diseased person should be removed to a hospital and placed under treatment." PRO/CO129/522/3. "Notes on printed papers, 1860-1900."

[63] See: Lenore Manderson. "Migration, Prostitution and Medical surveillance in early 20th century Malaya", in *Migrants, Minorities, and Health: Historical and Contemporary Studies*(London: Routledge, 1997) pp. 49-69.

[64] Ronald Hyam. *Empire and Sexuality*. p. 142.

[65] For more detailed accounts of Josephine Butler's writings and legacy, see: Jane Jordan and Ingrid Sharp (eds) *Josephine Butler and the Prostitution Campaigns: Diseases of the Body Politic, Vol 1-5* (London, New York: Routledge, 2003).

the sanctity of the (white) family unit found common grounds with radical suffrages and feminists opposing the denigration of the dignity of the female gender.[66] These activities took on international significance where abolitionists felt the need to push their governments for a more universal repeal of these regulations.[67]

Ronald Hyam traces the hardened stand against international prostitution from the 1900s to the influence of the temperance movement. He painted a situation where "many people's essentially harmless pleasures are now penalised, prostitution is being frowned upon[...]and even family photographs are being monitored."[68] Britain, he thought, had "exported to the international community the fearful intolerance and neurotic frustration which purity exacts as the price of its adoption."[69] Casting doubts on the wisdom of the abolitionists, Warren felt: "Closing the brothels after 1927 was a mistake. It left prostitutes to operate [...] clandestinely as individuals while venereal diseases continued to wreck havoc upon the Chinese population right up to the fall of Singapore."[70]

In this respect, Hyam, and to a lesser extent, Warren, subscribes to the argument of the social hygiene movement as essentially that of a moral police rather than an abolitionist front. While there are strong traces of the emphasis on Victorian sexual abstinence, this should not define the entire legacy of the women health movements in British Malaya. As this section will subsequently elaborate, the priorities of these women lobbyists were focused on the trafficking of Chinese women manifested through brothel prostitution and venereal diseases. In this respect, the CDO became one of the manifestations of the official tolerance of sexual slavery to which these activists were opposed.

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[66] See: Alan Hunt. *Governing Morals: A Social History of Moral Regulation* (United Kingdom: Cambridge University Press, 1999).
[67] From Elizabeth Andrew and Kate Bushnell's Report to Josphine Butler. "The Queen's Daughters in India." Penelope Tuson (ed) *The Queen's Daughters: An Anthology of Victorian Feminist Writers on Indians, 1857-1900* (Reading : Ithaca Press, 1996) p. 184.
[68] Hyam. *Empire and Sexuality*. p. 152.
[69] Ibid.
[70] Warren. *Ah Ku and Karayuki San*. p. 177.

Eventually, public pressures compelled Westminster to repeal this ordinance across the British Empire by the 1880s. This move shocked officials and community leaders in British Malaya. A committee was rapidly formed to show the containment of venereal diseases since the passing of the CDO, and its supposed relapse on an epidemic level since its repeal.[71] The only visible opposition came from the Bishop of Singapore, Reverend Shellabear who expressed his abhorrence to the indignities endured by the women subjects.[72] Highlighting the inherent hypocrisy of the measure in ascribing the transmission of venereal diseases only to women where men are equally responsible, he noted: "The man is as guilty as the woman. The man cannot be touched as he refuses to be touched; the woman we touch because she is in our power."[73]

Nonetheless, the committee's recommendations were rejected. Convinced London was compromising the public health of the colony by the repeal, the Malayan officials took a more discreet measure of medical examination of prostitutes on the pretext of protecting their health and welfare.[74] This led to another scandal breaking out in 1912 where *The Times* accused the administration of legally endorsing brothel prostitution through the medical component of the Protection of Women and Girls Ordinance.[75] However, the more sustained scrutiny of social hygiene in British Malaya came at the end of the First World War in 1918.

"We are Fight for those who cannot Fight for Themselves"

The massive mobilisation and movement of troops for the Great War corresponded with a parallel increase in infectious diseases, in particular venereal diseases like syphilis and gonorrhoea.[76] Various social hygiene organisations came further into public limelight as a result. The more internationally prominent organisations in Malaya were the National Council for Combating Venereal Disease or NCCVD (later renamed the British Social

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[71] PRO/CO273/543/3. *Report on Committee appointed by the Governor of the Straits Settlements on 24 November Contagious Diseases Act on Venereal Diseases, 1898.*

[72] Robert Hunt. *William Shellabear; A Biography* (Kuala Lumpur: University of Malaysia Press, 1996). p.139.

[73] *Report of the Committee appointed by the Governor of the Straits Settlements to look into Venereal Diseases 1898.*

[74] Not all medical officials agreed on the virtues of mandatory medical examination. According to the medical report of the Federated Malay States: "it does not appear that the old enactments, now withdrawn, had much influence in preventing venereal diseases which are so prevalent, especially among Malays and Chinese." *F.M.S.A.R.* 1913. p. 6.

[75] Warren. *Ah Ku and Karayuki San.* pp.155-160

[76] See: Philippa Levine. pp. 145-176.

Hygiene Council or BSHC), and the Association for Moral and Social Hygiene (AMSH). As stated in its annual report, the intention of the Association was: "[....]To raise the standards of character and conduct of sexual relations, to secure the recognition of an equal standard of morality for men and women, and to eradicate prostitution and all kinds of evil. It will oppose and seek to overthrow all forms of official regulations and commercial exploitation."[77]

The rationale behind its international involvement can be summed up as:

There is good reason to hope that no responsible government in any English speaking land will ever again venture to propose anything resembling the Contagious Disease Acts. But abolitionists cannot forget that there is a constant danger of the re-introduction of a similar system under some other guise; the two propositions against which they are desperately on guard are those for the detention of diseased persons in hospitals and notifications of diseases.[78]

In the meantime, from the 1910s, the local bodies like the Singapore Vigilance Society were beginning to influence sexual politics as well.[79] Their efforts were further energised by the visits of prominent international campaigners like Catherine Dixon.[80] In the launch of the local purity campaign in Singapore in 1919, she claimed:

[...]The existence of a recognised class of women in recognised houses is injustice to women, however necessary it may seem to men. Prostitutes are not born, they are made, trade with vested interests at the back of it and pressure is constantly being brought to bear upon those least fitted to resist it. We are fighting for those who cannot fight for themselves[81]

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[77] *The Shield*. Third Series Vol. II.Aug-Sept 1919 (Wellcome Library).
[78] *The Shield*. 12(30) August 1911. p. 5.
[79] Grace Human. "Licensed Brothels in Singapore (Letter to the editor of *The Shield*)" 25 April 1915. . WL..ASHM.3AMS/5/13. Malaya, 1888-1924. Prior to the purity campaign, the Singapore Vigilance Society chaired by Dr W.G. Shellabear of the Methodist Episcopal Church was involved in spreading the message of sexual abstinence in the colony. Under one of its secretariat, Miss Grace Human (who was also involved in the Ceylon Vigilance Society), the group conducted surveys of brothels in Singapore and disseminated abolitionist literature. However, due to the absence of publicity, little is known about this association. For details, see: Letter from Grace Human to Mr Gregory. 15 May 1915. WL..ASHM.3AMS/5/13. Malaya, 1888-1924.
[80] The wife of an English Chaplin in British India, Dixon was remembered as a significant player for campaigning against vice in the subcontinent. Association of Moral and Social Hygiene. *The Shield*. 11(3) November 1949. pp.33-34.(Wellcome Library)
[81] *S.T.* 15 March 1919. For details of Catherine Dixon's visit to Singapore, see also: *Monthly Paper of Saint Andrew's Cathedral*. Singapore, April 1919 (WL. 3AMS/5/13, Malaya 1888-1924).

Apart from urging the protection of women from vice, Dixon in her address to the inaugural meeting of the purity campaign, attacked the double standards of sexual morality embodied in the existence and toleration of brothels.[82] Resolutions were passed in the meeting setting out not just to "make the city clean and remove the magnet of evil from within", but also called for the abolition of all known brothels.[83] About a month later, another campaigner, Miss Strout from the World Christian Temperance Union, who had spent ten months in Singapore, delivered a series of lectures in Taiping, Perak urging an end to the semi-legal recognition of brothel prostitution in Malaya.[84] These meetings signalled the start of a sustained public campaign for abolition as well as cooperation between residents in Malaya and the London based social hygiene movements.

As noted in the correspondences of the BSHC and AMSH with the Bishop of Singapore and other interested parties based in Malaya, there was sustained exchange of information, ideas and encouragements. Highlighting the significance of such interactions, another prominent campaigner, Ferguson Davie who was also the Bishop's wife, pointed out: "it is important that we should have definite evidence on such points[...]before taking any actual steps[...]If public [and government opinion] is to be influenced, we must have facts, and a strong case to put before them." [85] Correspondently, the campaigns were also backed by a variety of community and civic organisations in Britain.[86] In effect, it was through such exchanges that the abolitionist cause deepened both its global and local scopes.

At around the same time, the head of the NCCVD (predecessor of the BSHC), Miss Neville-Rolfe made a study trip to enquire about the state of venereal diseases in the British Colonies in Asia. While Neville-Rolfe was compelled to acknowledge that the difference in cultural values made the total abolition of prostitution in the East more tedious, she stood firm on what she considered the inherent injustices in the CDO.[87]

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[82] *S.T.* 16 March 1919.
[83] *S.T.* 8 March 1919. A copy of the petition has been deposited in the Women's Library (WL. 3AMS/5/13. Malaya 1888-1924).
[84] *T.M.* 10 April 1919.
[85]WL.3AMS/5/13/Malaya. 1888-1924." From Ferguson Davie to Dr Helen Wilson." 16 August 1917.
[86] For details of these resolutions and correspondences, see: WL. 3/AMS.63.1. "Malaya: 1925-1955.
[87] See: Kerrie L. MacPherson. "Health and Empire: Britain's National Campaign to Combat Venereal Diseases in Shanghai, Hong Kong and Singapore", Roger Davidson and Lesley A. Hall (eds). *Sex,Sin and Suffering*. pp. 173-190.

Shortly after her visit, the Malayan government in collaboration with the medical services and the business community attempted to reintroduce the CDO by forming a committee to assess the situation of venereal diseases in Singapore in 1923.[88] In light of the controversies generated, the proceedings of the committee were held in private and its final report predictably supported the reinstatement of the regulation.[89] This proposal was however vigorously opposed.[90] Among the strongest opponents was a group calling itself the Social Service Society established by Mrs Ferguson Davie.[91] Under tremendous public pressure, another committee, which included the BSHC, was established.[92] With little deliberation, a counter-report was issued in 1926 calling for the maintenance of the status quo.[93] The Advisory Committee strongly opposed the reintroduction of compulsory medical examination on grounds that the method had not only been proven, clinically flawed, but socially and morally unacceptable.[94] It noted: "A system of compulsory periodic medical examination of prostitutes tends to hamper the success of any attempt to provide a comprehensive system of treatment of venereal disease for the whole population."[95]

It was clear too, the committee favoured the arguments of the abolitionists, not on moral reasons, but on that of public health with the argument when the:

Distinction between the East and West has been urged as a system, which has been found unsatisfactory in the West. But in as much as the limitation of disease is a primary objective of any system of state

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[88] For details of proceedings and report of Committee, see: *Report on the Committee on measures with regards to Contagious Diseases and Brothels with a view of checking Venereal Diseases. 1923.* PRO/CO273/659/13.

[89] See: Kemp. "An Investigation into the Social Hygiene Problem in Singapore during the 1920s" in *Journal of the South Seas Society*. pp. 81-93.

[90] See: AMSH memorandum on committee in: "The Proposed Re-Introduction of State Regulation of Vice in Singapore, 1924". WL. 3AMS/5/13.Box No: FL062, Malaya, 1888-1924.

[91] WL.AMS/5/13. Box FL062: Malaya 1888-1924. "From Mrs Ferguson Davie to Miss Alison Neilans. 7 December 1921."

[92] Aside from Rolfe, the other members of the committee from the BSHC and the ASMH were Mr. E.B Turner and Dr Douglas White. *First Report of the Advisory Committee on Social Hygiene*, 1925.

[93] For details of the proceedings of the Committee, see: PRO/CO/882/11. No. 147. "Straits Settlements: Correspondence relating to Social Hygiene in Singapore." October 1927.

[94] The reasons cited by the report was the difficulty in carrying out examinations with thoroughness, and even if that was possible, no prostitute could ever be safely declared free from gonorrhoea while syphilis could be reacquired. The women who might be healthy at examination may be infected shortly after and may infect many others before she can be detected. Most importantly, the report stated: "Wherever prostitutes are known to be subjected to compulsory periodic examination there results in men a false sense of security which tends to encourage promiscuity and to spread disease. Ibid. p.2.

[95] Ibid

regulation of prostitution, we must emphasize that the failure of such systems in Europe is explained on medical premises, which are equally valid in any part of the world.[96]

The Committee called for broader reforms in social conditions, expansion of treatment centres, suppression of all brothels, and providing wider protection to immigrant Chinese women.[97] In turn, this Committee was considered by the AMSH to be a milestone for the abolitionists in British Malaya where, "The most important point now will be to see that the recommendations of the Advisory Committee are put into operation."[98]

The Association was aware of the forces attempting to reverse the repeal. Despite expressing disappointment with the report, the pro-regulation elements were quietly pushing for a similar version of the CDO to be implemented in the Federated Malay States.[99] Again, this was promptly detected, compelling the Colonial Office to appoint a committee to review this move.[100] Displaying evidence of the increasing attendance of venereal disease treatments and the success of closing brothels, the committee cautioned against compulsory examination, which was in turn approved by London.[101] The issue of regulation again prominently resurfaced during the late 1930s with the build up of troops in Malaya to meet the increasing threat of Japanese military expansion. Pro-regulation supporters complained the banning of brothel prostitution and the repeal of

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[96]Ibid. pp.7-8.
[97]Ibid. p. 9.
[98] Association for Moral and Social Hygiene. *Annual Report.* p.31.
[99] Even though the policy of compulsory medical examination of women prostitute was abolished in the Federated Malay States in 1894, a section of the Protection of Women and Girls Ordinance permitted .the punishment of brothel owners who allowed prostitutes suffering from venereal diseases to carry on her trade. It was observed that the fine was usually transferred by the brothel to the prostitute. As such, unless legally compelled, the prostitute was often reluctant to consent to undergo voluntary medical examination. WL. 3/AMS.63.1. Malaya 1925-1955. "Report of a Committee appointed by the Secretary of State for the Colonies to examine and report on Straits Settlements Ordinance No.15 of 1927 (Women and Girls Protection Amendment Ordinance) and Federated Malay States Enactment No. 18 of 1927 (Women and Girls Protection Amendment Enactment). 1929. pp. 9-10.
[100] The request was put forward by the BSHC which had already fostered a relatively smooth working relationship with the Malayan authorities. See: British Social Hygiene Council: "Federated Malay States: Amendment to Protection of Women and Girls Act." WL. 3/AMS.6.3.1. Association for Moral and Social Hygiene. Malaya, 1925-55.
[101] Ibid. p. 15-16.The closure of the brothels did seem to have a positive impact on the autonomy of individual prostitutes, According to the 1933 report from League of Nation's Commission of Enquiry into the Traffic of Women and Children in the Far East, "The keepers of existing brothels now know that their establishments are doomed to be closed and many may be closed at any moment. Inmates who are unwilling victims realise under these circumstances that the power of the keepers has been shaken and that, if they wish to get free of their influence, they have the full support of the authorities." from: *The Shield.* Vol.II. No.2. April 1933. pp. 58-59.

the CDO had driven the sex trade underground, resulting in the proliferation of "sly prostitution" or freelance prostitutes who openly solicited on the streets.[102] Against this opinion were abolitionists emphasising on greater public education and anti-vice enforcement. As argued by a writer with the pseudonym of MEDICO in (probably)her letter to the *Straits Times* in 1941:

> If the prostitutes are to be medically examined, it is but reasonable that their clients also should be medically examined and certified free from disease before they can enter any house. Why should the clients be protected and not the women? If people should ask for licensed brothels for the protection of men, I appeal to the manhood and womanhood of this city to rise up and demand the same protection for their unfortunate and inarticulate sisters. This control of prostitutes is one sided and absolutely unfair, unjust and cruel.[103]

In 1940, Governor, Shenton Thomas commissioned a confidential study by Miss Sarah Nicoll-Jones on the situation of venereal diseases and brothel prostitution in Singapore.[104] Commenting on the importance of her role, the reputed abolitionist wrote: "As you will doubtless know, we are in a part of the world that might very much be in the limelight."[105] Admonishing against seeing limited medical regulation as a panacea for deeper social regulation, Nicoll-Jones argued for more holistic measures to protect and uplift the dignity of women in Singapore. This entailed the tightening of checks against abuses, establishment of legal and welfare institutions like Juvenile

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[102] According to the League of Nations, the systematic closure of brothels in Singapore forced brothels owners and traffickers to keep small lodging houses of rendezvous for Chinese prostitutes. Another alternate means was to disguise them as "waitresses" in coffee shops that sprung up along the city. In response, the colonial police had changed their strategy from targeting prostitutes to hunting down traffickers. League of Nations. *Commission of Enquiry into Traffic in Women and Children in the East.* Geneva: 10 December 1932, p.53. Contrary to the arguments of pro-regulation advocates, the Secretary of Chinese Affairs reported the success of the choking the financial sources and social control of triads and brothel owners on prostitutes with the moves to close down brothels completely. PRO/CO273.581/16 A.N. Jordan. Secretary of Chinese Affairs. "The Effects of the Abolition of known brothels in Malaya." 15 February 1932.

[103] *S.T.* 7 March 1941.

[104] Nicolle-Jones was approached by the Head of the Police in Singapore during his vacation in Geneva in 1938. He had earlier consulted Miss Neilans of the AMSH on the problem the police were facing in dealing with street soliciting by prostitutes after brothels were being closed down. Neilans recommended Nicoll-Jones on grounds of her experience of social hygiene work in Burma. "Mr Dickenson's Statement [On Nicolle-Jones]" *in The Shield.* Vol. XI. No.3, November 1949. pp.20-21 (Wellcome Library). For Nicoll-Jone's account of her experience in British Burma, see: Ibid. S. Nicoll-Jones. 6(3) December 1938. pp. 104-9.

[105] . Speech by A.H. Dinkinson and Mabel Cowlin. "Sarah (Sally) Nicoll-Jones" in The Shield Vol. X. No. 3. June 1947. p.15.

Courts, remand houses, training schools, and even a women police force.[106] The response of Governor Thomas below reflected the weight given to the report:

Miss Nicolle-Jones after a most exhaustive and realistic investigation has presented a report which penetrates thoroughly the facts of the situation which the government has found disquietly and made recommendations which are now being carefully studied, some of them might be expected to have immediate effect, but those which are radical have a long rang in time and scope[...]The fact that this government in such conditions is increasing its exertion to control prostitution at a time when it is sorely taxed by problems of war should not be an inadequate answer to the Association for Moral and Social Hygiene.[107]

Nicoll-Jones's report was not made public in light of the tensions generated. The confidentiality of the report however indicated strongly the influence of the social hygiene presence in the colonial civil society by the early 1940s.

By that time, the campaigners had already claimed success in pushing for the repeal of the CDO on venereal diseases in the British Crown Colonies. Reflecting this achievement, the AMSH commented:

It is noteworthy in one respect, namely, that we can now take down all the files and boxes of papers labelled "British Crown Colonies" and write across every one of them "Abolitionist legislation adopted." Those files began in 1882[...] In various places under British administration, brothels have been made illegal, and the traffic in women thereby either destroyed or seriously hampered, in the following order of dates: Colombo: 1912, Burma: 1921, Gibraltar: 1922, Malta: 1930, Straits Settlements: 1930, Federated Malay States: 1931, Hong Kong: 1931, Cyprus: 1932.[108]

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[106] Sarah Nicolle-Jones. *Report on the Problems of Prostitution in Singapore, 1941*. See also: S.C. Nicoll Jones. "Discussion on Prostitution in Singapore", Journal of the Malaya Branch of the British Medical Association. 6.1 (June 1941): 64-69.
[107] PRO/CO/825/1941. "From Shenton Thomas to Lord Moyne." 16 October 1941
[108] Association for Moral and Social Hygiene, *Annual Report*, 1932, p.8.

In effect, the stocktaking of the success of the abolitionist movement highlighted the concern of the international health lobbies on sexual politics in British Malaya, as well as the territory's global political significance.[109]

Generating Debate and Dissent

Correspondences however revealed a more difficult task behind the apparently successful efforts of the social hygiene movement. Despite the publicity generated, the activists could only rely on pockets of support in the colonies from mainly the local clergy and individual sympathisers.[110] The male dominated public opinion in British Malaya, ranging from government officials to the press and the merchant community, was overwhelmingly hostile to what they perceived as the interference by what they perceived as ignorant English ladies.[111] The *Straits Times* for example felt it was the policies on venereal diseases which would affect the outcome of the colony more adversely than defence contributions or opium revenues: "[...] whereas the people who shut down our opium traffic will only damage us in our pockets and complicate our administrative problems, those who are out to reform our sexual moralities will, if they get their way, strike at the foundation of our public health."[112]

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[109] From the mid 1920s, the Association extended its concerns of brothel prostitution to the practice of child slavery or "Mui Tsai" in Hong Kong and Malaya in which Chinese girls were being frequently sold as servants or raised to be prostitutes. For details of the AMSH's documents on the Mui Tsai system, see: ASHM. "Mui Tsai in Hong Kong and Malaya, 1919-1935, and 1936-1950". WL. 3/AMS/5/3-4/ Box: FL06-2.

[110] Strong support from the Straits Chinese community was shown to the Bishop's of Singapore attempts to defend the repeal of the CDO in 1924. A public meeting of prominent Chinese leaders, several of them Western trained doctors took place in March to protest against the colonial administration's exclusion of the representation of the Bishop in the 1923 Committee on Venereal Diseases which called for the CDO's resumption. *The Malayan Saturday Post*. 29 March 1924 (Taken from Women's Library collections: WL. Malaya: 1888-1924: 3AMS/5/13. Box: FL062,). The support was sustained by prominent Chinese individuals like Dr Chen Su Lan. Speaking at the Rotary Club in 1941, Chen criticised the local regulations for unjustly criminalising street soliciting. He suggested instead the provision of shelters for prostitutes and called for better facilities for the treatment and cure of venereal diseases. *S.T.* 20 February 1941. The Bishop of Singapore lent his support for the abolitionists with calls for Christians to abide by their religious duties of abstinence from sin and greater public education for the rest of the population. He also lamented the fallacies of compulsory medical examinations, a practice he considered only as "guarantee for the first client." *S.T.* 17 January 1941.

[111] Not all officials within the Malayan Medical Services supported regulation. Following the report of the secretive Committee on Venereal Diseases in Singapore, Dr. Tertius Clark, a former health officer expressed in a letter to the Bishop of Singapore his disgusted with the exaggerated figures and hostile attitude towards the clergy by the regulationists. WL. AMSH. Malaya 1888-1924. 3AMS/5/13. Box: FL062. "Letter from Dr. J. Tertius Clark." 13 January 1924.

[112] *S.T.* 19 Jan 1929.

The hostile sentiments the campaigners were confronted with was documented in a letter sent from the Secretary of the AMSH Alison Neilans where:

> Now while it is time that the political chiefs at the moment at the Colonial Office are on the whole sound in their ideas, the permanent officials and in particular, the officials out in Singapore and the Federated Malay States are almost to a man, regulationist. My Committee has as you know had over forty years of experience of the vileness of the regulationists in the Far East.[113]

Rifts were also developed among the campaigners regarding BSHC and the ASHM approach towards engaging the colonial state. Aside from it involvement with the local social hygiene committee, the former was requested by the authorities to provide expert advice on the provision anti-venereal diseases clinics and to supply public health education leaflets.[114] The AMSH however observed such cooperation compromised the Council's lobbying edge. Explaining its stance in a letter to the Association, the BSHC defended the government's apparent expediency, citing the impossibility of its tiny bureaucracy to realise the ideals of abolition.[115] However, the Association felt the BSHC sidestepped the core purpose of the social hygiene movement. As Neilans wrote privately "Mrs Rolfe's official position apparently prevented her from speaking out against regulation and the recognised brothels when she was out in the East. No one knows better than she what disappointment was caused [...]by her silence in public meetings on this subject."[116]

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[113]WL. 3/AMS/61..Association for Moral and Social Hygiene. Malaya: 1925-55. "Letter from Secretary Alison Neilans to Mrs Dumbleton." 5 December 1927

[114] Through the advice of the BSHC via the Advisory Committee to the Colonial Office, the colonial government expanded both its interest and infrastructure towards venereal disease treatments and sexual health education in Singapore. The Council appointed Professor Bostock Hill, Emeritus Professor of Public Health from the University of Birmingham as a consultant to the development of infrastructure on social hygiene. Hill visited the Straits Settlements twice between 1923-1927 to assess the government commitment to developing the social hygiene infrastructure in the colony. See: Professor Bostock Hill to the Straits Settlements and Ceylon, and "Report of Committee on Straits Settlements Ordinance No 15 of 1927 and Federated Malay States Enactment No. 18 of 1927. pp. 6-7. The public health education projects covered the creation of a Central Bureau of Information disseminating pamphlets on venereal diseases in the more common vernacular languages spoken in the colony. It had also roped in various public bodies and existing committees into a new Social hygiene Advisory Board. In addition, the colonial medical services included venereal disease treatment centres in the main government hospitals, and appointed a lady doctor to give public health lectures and advice to prostitutes in brothels. See: W.C. Kelly (Acting Chief Medical Officer, Social Hygiene). "Social Hygiene Work in Singapore", in *Health and Empire*. Vo.10. 1929, pp.47-52. (Wellcome Library).

[115]WL.3/AMS.63.1. "Association for Moral and Social Hygiene, Malaya: 1925-55." Letter from British Social Hygiene Council to Association for Moral and Social Hygiene." 6 December 1927.

[116] WL.3/AMS.63.1.Association for Moral and Social Hygiene. Malaya, 1925-55. Executive Committee's rough notes on British Social Hygiene Council's letter. 10 Dec 1927. The AMSH had also suspected the BSHC's restrain on criticising the government to the latter's generous funding of the

The rifts between the two organisations revealed problems in the different approaches of the social hygiene movement. Cooperation with the colonial authorities brought the BSHC access to influence the public health infrastructure and policies.[117] The AMSH on the contrary, remained largely excluded for their public criticisms. But, reiterating the importance of agitation in its 1933 report, the Association believed:

> We have always believed that it is propaganda and controversy over an idea which is the real education and, not the actual gaining of the point. It is the discussion and controversy over abolition and for an equal moral standard, not for final legislative victory, which is the really important factor in changing people's outlook.[118]

Even as the BSHC managed to heighten the priority of social hygiene, it was the AMSH persistent monitoring and contestations that denied re-reintroduction of the CDO or permitted "tolerated brothels" to exist officially in Malaya. Nevertheless, the influence of the key social hygiene campaigners ebbed by the 1940s after more than two decades of active involvement in the colony. Choosing to stay in Singapore after the completion of her report in 1941, Nicoll-Jones became an unfortunate casualty of the Japanese invasion.[119] Alison Neilans passed away in 1943, while Neville Rolfe retired from the BSHC almost within the same period.[120]

Council, particularly with the visit of its members to Malaya, amounting to £9,050 pounds. Ibid. "Letter from Miss Neilans to Miss Shepard". 8 December 1927.

[117] An example of the BSHC more moderate tactics was over the debate on the response to the 1923 report by the Straits Settlements Committee urging for a return to the CDO on compulsory examination of prostitutes. There were calls within the Council to publicly raise the issue in Parliament to embarrass the government. But, it was finally decided that a more "unofficial" method of arranging for a deputation of Parliamentarians from the various political parties to "wait on the Secretary of State for the Colonies and recommend for the appointment of a Social Hygiene Advisory Committee [with the inclusion of the BSHC]." Consisting of three Members of Parliament, including the prominent Lady Astor, the deputation successfully lobbied the Secretary to withhold the recommendations of the Straits Settlements Committee. British Social Hygiene Council. "Minutes of meeting of Parliamentary Committee." 24 March 1924. pp. 2-3 (Wellcome Library, SA/BSH Box 37).

[118] The Association for Moral and Social Hygiene. *Annual Report*. 1933. p. 8 (Wellcome Library).

[119] After submitting her report, Nicoll-Jones continued to give lectures on social hygiene before becoming a camp commandant for Japanese women and children prisoner of war in Singapore shortly after Japan's invasion of Malaya in December 1941. With the transfer of these prisoners to British India, she assisted in relief efforts for children orphaned or separated by the conflict. She reluctantly left Singapore as the Japanese closed in but her ship, the *Queen Bee* was torpedoed. Nicoll Jones was never found. Speech by A.H. Dikinson and Mabel Cowlin. "Sarah (Sally) Nicoll-Jones" in *The Shield* Vol. X. No. 3. June 1947. p.21-23 (Wellcome Library).

[120] After serving the Association as Secretary for more than two decades Neilans suffered a stroke in 1941 and passed away on 17 July 1942. See: *Supplement to The Shield: In Memoriam, Alison.R.N. Neilans (1884-1942)* April 1943. For details of Neville Rolfe's retirement, see: "Mrs Neville Rolfe, formerly Gotto-May, archive material" Wellcome Library. SA/EUG/C.294:Box AMS/MF/112.

Conclusion: From wives and prostitutes to doctors and abolitionists

In many respects, medical practitioners and public health campaigners in Malaya took relatively different approaches in platforming maternal and sexual health. While the former brought healthcare provisions to indigenous mothers and infants, the latter lobbied against the mandatory medical examination of prostitutes. In spite of their evangelistic ideals and disdain for folk midwifery practices, the women doctors were more focused on healing bodies rather than souls. From the opening of the first dispensary, they expanded the scope of modern maternal and infant health services in the colony. Similarly, the social hygiene movement persistently pressed for the repeal of the controversial CDO in British Malaya. Faced with hostile public reactions from the political and merchant elite, the abolitions were also split amongst themselves in deciding on the appropriate means of dealing with the colonial state.

The involvement of Western women impacted on colonial civil society more poignantly than just being represented as doctors and lobbyists. Medical missionaries like Doctors Warren and Staley and abolitionists like Neville- Rolfe and Nicole-Jones had simultaneously strengthened and rattled the social status quo in British Malaya. In one respect, the Empire and its colonies gave British women the opportunities for the types of work unavailable to them at home, and permitted social activists to spread their agendas outside the British isles.[121] In assuming the "White woman's burden", these activists had engendered another layer of European hegemonic control over local womenfolk who were portrayed as unenlightened and passive objects who had to be emancipated by Western tutelage.

It seemed however, that the insertion of this group posed a greater challenge to the patriarchal colonial order in the territory, particularly in the case of the abolitionists. One unintended outcome of their presence was the heightened participation from women within colonial civil society who capitalised on these gendered activities to enlarge their public spaces. At the same time, these health lobbies had also generated increasing social consciousness on women's issues ranging from the availability and access of maternal and infant healthcare services to the trafficking of women and sexual slavery. While the voluntary activities of European women in the medical mission were

[121] Alison Bashford. "Medicine. Gender and Empire", in Levine (ed). *Gender & Empire.* pp.120-1

encouraged, the purity campaigns seemed to cause unease among colonial civil society. The heated contestations over social hygiene reflect Levine's emphasis of sex being an important part of politics of Empire. Seen to threaten the bulwarks of Empire and civilisation, "sex needed to be restrained and reined in."[122] In effect, the sexual politics split colonial civil society into the camps of abolitionists and regulationists. This dichotomy revealed in turn the contrasting worldviews of health lobbies in British Malaya between pragmatists contended with a measured level of containment against idealists pushing for the total suppression of vice. These contentions have in turn underscored the use of discourses of medical science to articulate undercurrent anxieties of British presence in Malaya merely as custodians of a burgeoning colonial economy or messengers of Western civilisation.

The ideological rifts between the two camps also reflected wider tensions between the local and global in colonial health politics. While the pro-regulation body consisted mainly of powerful public opinion of senior officials and merchant leaders in Malaya, it was the abolitionists who commanded a more global following. By raising public consciousness in the United Kingdom, forging alliances with similar groups in other countries and dominating the related committees within the League of Nations, the abolitionists managed to gain the upper hand. In essence, the experiences of the health lobbies in politics of social hygiene demonstrated the layered intersections operating between the local and global in British Malaya.

Nonetheless these health lobbies in British Malaya ebbed by both the disruption of the Japanese occupation and subsequent plans by the Colonial Office to assume larger responsibility in public health. While acknowledging the services of the BSHC, London felt strongly that "measures to deal with venereal diseases should be regarded as an ordinary duty of the state public health authorities and should not be entrusted to an unofficial voluntary body".[123] The Secretary of State for the Colonies "made it clear that he could not regard it as appropriate that a voluntary body such as the council should be considered as occupying any special or official position in relation to the colonies."[124] Gradually, public consciousness of social hygiene issues in British Malaya faded away

[122] Ibid. Philippa Levine. "Sexuality, Gender and Empire". p.134-5.
[123] PRO/CO859/61. "Relationship between the Colonial Office and the British Social Hygiene Council." 19 February 1942.
[124] Ibid. October 1942.

after the war.[125] The hospital services of the maternal missions however outlasted the Second World War and the turbulent periods of decolonisation and industralisation in Malaysia and Singapore. Nonetheless, in its annual report in 1949, the Saint Andrew's Mission Hospital questioned its own relevance in light of the colonial government's plans to assume larger responsibilities in medical provisions.[126] This question on the relationship between state and civil society in the historiography of medicine will be assessed in the final chapter concluding the discussions of health lobbies in British Malaya.

[125] Beyond expressing concerns about the possible re-introduction of the CDO in the 1950s, the AMSH presence in British Malaya was comparatively paler than the pre-war years. The last correspondence relating to the region was in 1955. See: WL.3/AMS.63.1. "Malaya, 1925-55.
[126] Saint Andrew's Mission Hospital, *Annual Report*, 1949. p. 8.

Conclusion: What is Politically Possible

Now that the great majority of prisoners of war have returned from the Far East, I write to say how intensely I and those with me appreciated all that the British Red Cross Society was doing and was trying to do for us. In my camp we received bulk supplies from the society in March 1943 and a parcel each in April 1943[...]They arrived when things are at their worst and we were walking skeletons[...]I think indeed what cheered us almost as much as the stores themselves was the realisation of the wonderful sympathy and care with which every item had been chosen for our own good.[1]

Letter from former Governor of Singapore Shenton Thomas to British Red Cross in 1945

One kind of politics threatened colonial regimes with unending violence and the possibility of a unified opposition; the other challenged them with the possibility of political action would produce concrete gains for different categories of people within a colony, that ideologies might be reconfigured, and that notions of what is politically possible or excluded might shift. [2]

Frederick Cooper

Shortly after surrendering Singapore to the invading Japanese army on 15 February 1942, almost the entire European community, including the Governor, was marched to internment. In the midst of the harshest years of the occupation, the health lobby in Malaya did not lose its relevance, at least to some of the Allied Prisoners of War (POWs). Operating in Singapore under politically ambiguous and restrictive conditions, a Swiss representative of the International Red Cross, Mr Schweizer, became the intermediary between the belligerents during the Second World War. Tasked with the job of monitoring the humanitarian situation in the colony as well as the welfare of POWs, Schweizer managed to negotiate for the delivery of supplies for the internees.[3] However minor its role in the grand narrative of the war, the Red Cross became useful in precariously mediating between the remnants of the collapsed colonial social order and their usurpers. His presence here serves as a postscript to the discussion of health lobbies in pre-war British Malaya within the contexts of state-civil society relations and discourses on modern medicine.

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[1] PRO/CO980/151. Letter from Shenton Thomas to British Red Cross in *The Times*. 24 December 1945. For details of the British Red Cross operations in Asia during the Second World War, see: P.G. Cambray and G.G.B. Briggs. *Red Cross and St John: The Official Record of the Humanitarian Services of the War Organisation of the British Red Cross Society and Order of St John of Jerusalem, 1939-47.* (London: British Red Cross, 1949) pp.87-93, 393-397.

[2] Frederick Cooper. *Colonialism in question: Theory, knowledge, History*. p. 232.

[3] PRO/CO980/48. "International Red Cross & British Red Cross: Relief Malaya."

This concluding chapter assesses the activities of the health movements in shaping the medico-social landscape of British Malaya. Discussed separately in the previous chapters, the experiences and legacies of these groups will be pulled together for a more holistic appreciation. Their activities have also facilitated the possibility of hierarchicalising colonial civil society's varying interests on diseases. As such, the assessment of the health movements in the past six chapters calls for a review both the broader debates on postcolonialism and globalisation as well as the particularities of Malayan history.

Initiating Medicine: Body Natural and Body Politic

Conventionally tied to the introduction of "modern" Western medicine into the territory, the British legacy was first celebrated for delivering the fruits of progress. The same legacy was subsequently regarded as the extension of colonial hegemony. As argued in Chapter One, such portrayals frequently represent the colonial public health regime as an ahistorical monolith rather than a haphazardly evolving agency, and society as a passive entity instead of an active participant.[4] However, the municipal and estate hospitals, malaria drainage works, rural health centres, maternal health clinics, latrines systems and other medical institutions were either initiated or funded by non-government bodies. Aside from the locally based merchant and planting communities in towns and agricultural plantation estates, other international players included the Anglican medical mission and the Rockefeller Foundation were also involved in expanding the colonial public health infrastructure. The introduction of more specific treatments and prevention of malaria, hookworm infection, narcotic addiction and venereal diseases, and the accompanying propagation of public health education was also initially carried out by health lobbies rather than the colonial medical services. In addition, these health movements managed to provide and coordinate emergency relief efforts during the 1918 influenza pandemic when official presence was lacking. Many of these early community initiatives were subsequently appropriated and expanded upon by the government.

In spite of the comparatively smaller levels of involvements than the state, these health movements and community organisations reached areas where the colonial medical

[4] In her concluding remarks on public health in British Malaya, Manderson continues to invoke the narrative of the colonial state exclusively as the main driving force of development in the colony through the extension of the colonial medical services. Manderson. *Sickness and the State.* pp. 231-242.

services had had yet to touch. While there was no intention of these health lobbies to take over what they perceived as state responsibilities, their motivations were diverse. Merchant leaders and plantation managers were probably goaded by a mixture of the humanitarian impulses, economic necessity and social prestige to fund hospitals for paupers in the urban centres and plantations. For the IHB and temperance movements, raising awareness of hookworm diseases, rehabilitating opium smokers and promoting sexual discipline were concrete measures behind more intangible ideals.

Accompanying the supplementary role in the provision and extension of the public health and medical infrastructure was a more contested engagement of health lobbies with the authorities. Underlying the grievances against of the existing public health services or policies were desires for greater government involvement in the colony's health. In infrastructure terms, this meant more, and better-equipped and smoothly functioning hospitals and quarantine centres as well as increasing regularity in sanitary and public health maintenance and inspectorate works. Indignant at being blamed for high mortality rates among their workers, planters called for the state to play its part in estate health and anti-malaria works. Similarly, the Rockefeller representatives urged for official commitment towards rural health as well as public health education. The demands for a more interventionist public health regime came more stridently from the temperance groups. Dissatisfied with what they saw as expedient licensed opium trade and mandatory examination of prostitutes, anti-opium societies and social hygiene movement urged for total abolition. These measures, considered drastic by some in a colony where such trades were prevalent, entailed the immediate criminalisation of opium consumption and brothel prostitution by the state.

Aside from carefully selected government committees and responses to issues raised in the Legislative Councils, there seemed to be few formal channels of engagement between the authorities and health lobbies. Hence, the colonial medical services did not seem interested in defending itself from public criticisms commonly articulated in the newspapers. Nevertheless, health lobbies managed to compel officialdom to take their agendas more seriously through either their economic clout or their influence on public opinion. Relying on the financial and technical contributions to the development of medical facilities by merchant leaders, planters, the Rockefeller representatives, and medical missions, the government was inevitably compelled to consider their grievances

and suggestions. Even without the financial might, temperance groups were still able to influence public health policies from their ability to mobilise and sway local and international public opinions.

On the government's part, accommodating these interests depended on the degree in which they impacted on both its politico-moral legitimacy as well as the extent in which the colonial bureaucracy could realistically manage. With the mythos of colonial hegemony established along progressive modernity of Western civilisation, the authorities found themselves challenged when the same rhetoric deployed against them by health lobbies. Appealing to the ideals of parliamentary democracy and civil society, the latter had also constantly portrayed the Malayan government as being despotic when policies were seen to be arbitrary. The measures undertaken by the colonial authorities to deflect these criticisms and uphold its legitimacy were in turn calibrated along the considerations of its actual ability to actualise the seemingly lofty demands of the health lobbies. As the cases of the complicated arrangements between the colonial health authorities and planters in the Local Health Boards, the apparently awkward policies towards opium suppression and venereal diseases have shown, these considerations became deeply problematic. On the premises of its miniscule bureaucratic apparatus and limited political authority, the authorities argued any radical shifts proposed by the abolitionists would be impractical.

However, with the increasing pressure from the Colonial Office swayed by pro-abolition public opinion, Singapore was compelled into following a more consistent direction determined by London. During the Inter-War period, the ambiguity of these policies became a reflection of the clumsy attempts of the government to appease competing health lobbies. Overall, these contestations in British Malaya signalled an emergent political culture of civil society resembling the Western European ideal polity of civil society based on the principle of autonomous voluntary associations and reasoned communications of free and equal individuals. Such was carried out in a public sphere which penetrated the state through the parliamentary principle, dissolving the absolutist *arcana imperii*.[5]

[5] John Gooly. "Civil Society in an Extra-European Perspective", in Sudipta Kaviraj and Sunil Khilnani (eds). *Civil Society: Histories and Possibilities* (United Kingdom: Cambridge University Press, 2001) p. 150.

Aside from contributions to public health facilities and policies, health lobbies manifested undercurrent anxieties of colonial civil society in British Malaya. While all groups expressed dissatisfaction with the state of health in the colony, their agendas differed. At one end of the spectrum were parties contented with rationalising and extending the existing public health regime and infrastructure. There were other health movements that believed that education was more important than legislation as they propagated the virtues of modern medicine and preventive health. At the other end, were groups which regarded diseases as syndromes of larger moral and social decay, where medical measures were only expedient without being accompanied by the removal of the temptations of vice.

To merchants and planters, a "Clean Bill of Health" was essential to the freedom of trade with which the prosperity of the British Empire was founded. Paradoxically, even as they clamoured for greater government commitment, these groups were equally wary of restrictive regulations that would translate to increased red tape and taxation, of which were felt to threaten private property and stifled industry. For those outside the business fraternity, the interest in public health was established upon more intangible principles. To the IHB, the medical mission and the abolitionists, British Malaya was regarded as a backwater of ignorance and a Babylon of vice to be civilised by the message of modernity through modern medicine. For the Rockefeller representatives and the European women missionaries, public health education was given significantly higher priority than hospital buildings as a means of enlightening the natives from their seemingly primitive practices.

In their activities, the health lobbies found simultaneously overlapping, converging and conflicting interests. Generally, the provisions of medical services, facilities and public health education were strongly commended. Among the interested players was a general consensus on the primacy of modern medicine and public health to improve the conditions of colonial Malaya and its inhabitants. Previously focused on medical institutions serving curative functions, colonial civil society welcomed the change in focus by the 1910s on preventive and public health education effected by the medical missions, the IHB and the temperance groups. The disagreements came when the abolitionists' radical campaigns against vices of opium and prostitution were resisted by

those contended with limited public health regulatory measures on narcotic addiction and venereal diseases. The former became associated with increasingly well intentioned but misguided interference that had resulted in significantly losses in opium revenues and epidemic prevalence of venereal diseases.

Manderson recognises the "tensions between political, economic and social-moral goals were played out in all field in the colony."[6] Nonetheless, her project seemed to be dominated by the emphasis on the agenda of the colonial state of simply using health to serve the needs of capitalism and legitimising colonial political rule.[7] As shown in the extent in which the health lobbies moulded public health policies, the debate were not theoretical as she claimed.[8] Assuming a more nuanced manifestation, they revealed the undercurrent of tensions between central control and colonial autonomy, the acceptance of a morally and culturally expedient status quo against a more utopian order.

Naming the "Worst Enemy"

Extracting from the Wembley Handbook of Hygiene, L. Richmond Wheeler wrote in 1927: "malaria easily heads the list as the most important cause of diseases and death. It induces a high death rate and a low birth rate, and is one of the chief reasons why such large tracts of fertile land in Malaya remain sparsely populated and undeveloped."[9] Behind this "worst enemy", Wheeler listed the other diseases like ankylostomiasis and tuberculosis as lesser evils.[10] I suspect that his view of the packing hierarchy of diseases according to mortality rates has been shared by those in his generation and reflexively adopted by historians as well. From the study of legacies of the health lobbies in British Malaya, a different mode of thinking is required to understand the sum of all fears. While clinical syndromes (degree of pain), transmission and mortality rates can indicate their enormities, these quantitative gauges alone are insufficient to reveal the latent anxieties accorded to individual diseases. Even as Rosenberg does not dismiss the biological basis of diseases, he stresses the importance of the collective socio-institutional responses that the sufferer's felt symptoms elicits.[11] In the case of Malaya,

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[6] Manderson. *Sickness and the State*. p. 242.
[7] Ibid. pp.233-235.
[8] Ibid. p. 242.
[9] L. Richmond Wheeler. *The Modern Malay*. p. 263.
[10] Ibid.
[11] Charles Rosenberg. "What is Disease: In Memory of Owsei Temkin", *Bulletin of the History of Medicine* 77.3 (2003): 491-505. p. 498.

the collective responses should not only be seen through the mortality figures of the diseases alone, as many historians have derived, but a range of other sources as well.

From the colonial medical reports, it seemed the sum of all fears in public health of the authorities were that of plague, smallpox and cholera, although the death tolls were insignificant compared to malaria, beri-beri and tuberculosis. However, a more crystallised hierarchy can be detected by the concerns of the health lobbies in the extent in which they captured public imagination over the fear of diseases. In appearance, each disease seemed to be confined to its socio-geographical contexts of the municipalities, plantations and villages. But, the crucial difference lay in the intensity and duration of the concerns for these afflictions. In some ways, the health lobbies had successfully spotlighted diseases as significant problems facing the colony. But, the attention span seems to be comparatively longest when it came to venereal diseases. On appearance, it was apparently limited to urban prostitution, and its death rates arising measured below that of the influenza epidemic and other endemic diseases. Nonetheless, it preoccupied the colony from the 1860s to 1942. Compared to lucrative opium revenues, cost from sick estate workers or delays of ships at quarantine centres, the economic stakes in venereal diseases were apparently less measurable. But, because of its complicated association with brothel prostitution, trafficking of women, control of Chinese secret societies and sexual health of troops, social hygiene commanded the public spotlight more prominently.

Opium suppression might had have shared the same heated contestations with venereal diseases. However, being mainly an issue pertaining to the ethnic Chinese community, its importance is suspected here to rank behind that of venereal diseases. Just on mere body count alone, malaria would have had been considered the most lethal disease of the tropics, being regarded as commonly as the chief obstacle to modernity and colonial expansion in the non-Western world. Despite its prevalence, malaria was almost exclusively appropriated to fit the agendas of the planting community and the medical fraternity. Comparatively, the urban health seemed to be given a lower regard by the early 20th century in spite of the growing problem of slums and tuberculosis associated with the congested and unhygienic living conditions. But, unlike the heated exchanges over vice and disease, there were significantly less disagreements of how public health regulations in the colonial towns unless they were carried out at the expense of private

property. As for rural health, it was only the international health movements like the medical mission and the Rockefeller Foundation that had demonstrated significant interests. At the bottom of this hierarchy would be that of influenza. Despite initial panic, with the absence of subsequent major outbreaks, the pandemic faded quickly from public memory.

The prioritisation of diseases by health lobbies here opens new questions to the notions of the differences between the culturalist and epidemiologist framing of diseases. In this respect, the varying fear of diseases is based as much on their possible socio-cultural and economic ramifications as much as their epidemiological impacts. Hence, in the case of British Malaya, it was more in the untold fears of sickness rather than the numbers that had fallen ill that reveals more critical insights into the underlying tensions of society than that of statistical indicators. Despite providing curative services, the proportionately greater emphasis on preventive health by these social bodies reflected their priorities in stating what could happen rather than what was happening to the body.

(Transnational) Colonial Civil Society

At the same time, the struggle to platform diseases and public health agendas mirrored the process in which colonial civil society shaped, and was shaped by modern medical discourses. This became the medium for which groups defined interests, fostered networks, marginalized rivals and consolidated positions. Merchants and planters used, or associated themselves with the understanding of modern sanitary science, bacteriology and malarialogy to rationalise their demands on the state. Similarly, without possessing medical expertise on maternal and rural health, it would have been significantly more difficult for the American IHB representatives and European women medical missionaries to be given official access and public endorsement to operate in the Malay heartlands. Similarly, the temperance movement also framed their moral arguments along modern medical pretexts in order not to be sidelined. Once dismissed as ignorant crusaders, the abolitionists confidently deployed the authority of medical science to support their moral arguments, effectively wrestling the monopoly of knowledge from the regulationists as a result.

Modern ideas of public health and medicine became simultaneously barriers and vehicles of access into the broader arena of colonial civil society and influence on

official policies. As shown in this project, various interest groups and health movements had made use of medical knowledge to further legitimise their positions. The chief beneficiary of the association with modern medicine was the predominately male British community. Although numerically marginal, they were instrumental in influencing the colony's political and social cultures. The rules of engagement in colonial civil society of sports clubs, town hall meetings, parliamentary committees trade associations, media and gala dinners were patterned strongly along the English model. The apparently Englishness of Malayan civil society was also reinforced by colonial bureaucracy with the English language as the formal mode of communication. As the colonial state expanded, the modus operandi of its apparatus became increasingly rationalised and specialised along European patterns. In effect, relations with the colonial administration, including its medical services, and policies, necessitated the use of the language of modern science and medicine.

While privileging the British colonial interests, biomedical sciences had also eased the entry of other groups into more meaningful social participation. Although widely disdained as trade competitors, the Americans were nevertheless able to gain a more concrete presence in the territory through the Rockefeller philanthropic enterprise. Meanwhile, the British women medical missionaries did not face the hostility the Americans encountered. But, in a colonial society where European women were confined to the domestic realm, the mission became one of the few outlets for public participation. Unlike the grudging acceptance of the Americans, or the token welcome of the medical missionaries, the entry of the women based social hygiene movements was viewed with contempt. Nevertheless, the blatant protests in the local newspapers of these supposedly ignorant English ladies did not deter them from muscling their way into the scene.

It was perhaps the ethnic Chinese community in British Malaya who were more successful in penetrating into the Anglo-Saxon domain of colonial civil society through medicine. Despite belonging to a wide range of linguistic and regional groups, the ethnic Chinese population was demographically and economically difficult to ignore with its capital and labour literally underwriting the development of the colony. The community on its part, found it necessary to engage with colonial civil society as a move to expand on their influence and maintain their precarious status. Being well

versed in the western socio-political culture as well as science and technological innovations was therefore imperative. Furthermore, with little assistance in especially the early years of the colonial settlement, the ethnic Chinese were compelled to be self-reliant. Hence, prominent Chinese merchants played the role of community leaders and philanthropists in financing the development of modern medical facilities and other social services.

By the 1890s, a generation of Chinese leaders schooled in Western institutions and cultures in Malaya and Britain began to deepen their involvement with colonial civil society. The more significant manifestation of the prominence of the ethnic Chinese community in colonial civil society was their lobbying efforts towards opium suppression. Activists like Chen Su Lan, Wu Lien Teh and Lim Boon Keng managed to place the problem of opium addiction at the forefront of public health in the colony. They capitalised on the contemporary trends of Western medical thinking to put forward their cases in the media, social clubs and medical journals as well as mobilising public opinion in mass campaigns and public health education literature.

Overall, the participation of these groups served to place health politics in British Malaya in a broader regional and international context. In many respects, the strategies of these groups and the political cultures they engendered has been similar to their contemporary counterparts described by Margaret Keck and Kathryn Sikkink:

> By building new links among actors in civil societies, states and international organisations, they multiply the channels of access to the international system[...]They also make international resources available to new actors in domestic political and social struggles. By thus blurring the boundaries between a state relations with its own nationals and the recourse both citizens and states have to the international system, advocacy networks are helping to transform the practice of national sovereignty.[12]

The plantation associations in Malaya were intricately affiliated with not just the joint-stock companies in the United Kingdom, but also the Rubber Grower's Association. Similarly, the mega profits of Rockefeller's Standard Oil Corporation gave him unprecedented worldwide reach in his philanthropic ideals of disease eradication. Matching the energies of private enterprise was the League of Nations, a product of the

[12] Margaret Keck and Kathryn Sikkink. *Activists Beyond Borders: Advocacy Networks in International Politics* (USA: Cornell University Press, 1998) pp.1-2.

First World War. With the choice of stationing the Far Eastern Epidemiological Intelligence Bureau, in addition to surveys of opium culture and prostitution in British Malaya, the League brought the colonial outpost closer international attention. The medical missions and the Social Hygiene movements in Malaya were also part of the internationalisation of health politics facilitated by the European imperial expansion. In the same light, the appearance of ethnic Chinese dominated anti-opium movements in the colony was engendered by trans-national migration, ascendancy of Chinese nationalism and the influence of Western temperance ideals. With such intersecting networks of health and medicine running through British Malaya, health politics was no longer regarded as a local matter. Borrowing from the terminology used by Ann Florini in her analysis of the globalisation of advocacy groups, the transnational colonial civil society in Malaya can be considered as a "Third Force" with a "long tradition."[13]

Mixing Universalities with Contexts

The Health lobbies in British Malaya reveals insufficiently conceptualised complexities. In its essence, this project zigzags across three historiographical streams, namely, the general discourses of social medicine, its context within postcolonial revisionism and the particular geographical settings of Malaya. As the thesis of medicine as a social discourse has allegedly been saturated, it is proposed to consider the theme of medicine as a mobilising tool. In this case, plagues and healing arts are not only embodied with social meanings, but also simultaneously rallying grounds. Health and medicine became the platform for individuals and institutions to organise support to meet larger ends. Moreover, the discourses of medicine have been conventionally confined around the doctor-patient relationship or the state medical services and society. As the health movements in British Malaya demonstrated, such interactions should also encompass a wider field of players, not necessarily from the medical professions, institutions or practices. An additional limitation of mainstream medical historiography has been absence of clearer links between the local and global. This can actually be seen as a more malignant aspect of national histories and Anglo-American historiography that has been construed and confused as being universal. As Mirsepassi, Basu, and Weaver point out,

[13] Ann Florini. *The Third Force: The Rise of Transnational Civil Society* (Tokyo: Japan Centre for International Exchange.2000) pp. 1-8.

The distinction between academic disciplines and area studies is rooted in a narrative of Western modernity. Disciplinary knowledge, which makes supposedly universalistic claims, comes out of the experience of modern European societies. By contrast, area studies knowledge, which makes supposedly particularistic claims, speaks about the non-Western world and thereby stands in a problematic and even contested relationship to disciplinary knowledge.[14]

As such, modernity and the modern medical discourse cannot be seen as merely the experience of the West. Again, the examination of health lobbies has shown how the colony became a multi-layered site of international, regional and local health politics. But, instead of a case of the particular being abstracted, their experience reflects more on the localisation of the global as these groups struggled to position their discourses within colonial civil society.

The interactions between the universal and the particular involve however the hegemonic and unequal relationships especially in the context of European colonialism in the non-Western world. Lamenting the limited engagements between the two fields of colonial and medical historiographies on both theoretical and empirical platforms, Vineeta Sinha finds that an explicit connection would produce a more comprehensive account of health both at "home" and in the territories.[15] Modern medicine and public health were regarded as another dimension of the imposition of Western forms of control on indigenous populations. This was in turn manifested in the apparently overshadowing influence of the superstructure of the colonial government medical services on their subjects. In Malaya however, the expansion of the colonial administration had generally lagged behind the spread of its political influence. Its hegemony on society was not total, but mediated by the agendas of diverse interest groups. In this respect, it would be more accurate to view medical authority not necessarily being centred within the colonial state as suggested by Manderson,[16] but diffused among sections of society. With a more pluralized perspective, it has become possible to perceive how society at large, and health movements in particular, reinforced, accommodated or challenged the colonial political structure.

[14] Ali Mirsepassi, Amerita Basu and Frederick Weaver (eds). *Localising Knowledge in a Globalizing World: Recasting the Area Studies Debate* (Syracuse, New York: Syracuse University Press, 2003) p. 6.
[15] Vineeta Sinha, "British Colonial Rhetoric on 'Modern Medicine' and 'Health at Home': Realities of Health Conditions in 19th century Britain", Srilata Ravi, Mario Rutten & Goh Beng Lian et al. *Asia in Europe, Europe in Asia* (Singapore: Institute of Southeast Asian Studies: 2004) p. 185.
[16] Manderson. *Sickness & the State*. pp.231-33.

The relationship is not only limited to that with the state, but among health lobbies within colonial civil society. The past chapters have shown a very fluid interaction consisting of expedient alignment of interests among the parties involved. This was visibly demonstrated in the support rendered by the colonial newspapers to the demands of the merchant and planting groups about urban and estate health issues as well as the various collaborations between health lobbies in the areas of providing relief during the influenza epidemic. Fractures within these health lobbies were also visible in the cases of the politics of opium and venereal diseases. The debate over these issues reconfigured more complex alliances than that between state and civil society.

While there were reservations about the claims of the Anti-Opium societies on the evils of the drug, the rifts over the CDO were played fully in the open. Malayan officials and their supporters within the local press and other business interest aligned themselves in opposition against the women based social hygiene groups and their sympathisers within local Christian and women's groups. In the cases of Chapter Six and Seven, regional and international bodies were also factored into the arena as temperance groups sought to simultaneously localise and internationalise their lobbying efforts. As there are no neatly defined categories of engagement, the understanding of the discourses of the health lobbies becomes, in the words of Ritu Birla, to "circumvent intentionality [which] resists apology for colonialism on the one hand, and the easy notion of a conspiratorial colonial project on the other hand."[17] Hence, this rather murky interaction of the health lobbies and officialdoms is not indicative of a conscious imposition of a British imperial order from the Colonial Office in London.

Other than medical and postcolonial historiographical discourses, the activities of the health movements open new frontiers for historical writings on Malaysia and Singapore. With the predominance given to the evolution of state and its related administrators, society's involvement with medicine has taken a backstage. These writings in turn create the problematic assumptions of the state leviathan as the sole mover of history. To Joel Migdal, it has the tendency to strip components of society of their volition of agency, portraying them as malleable in the hands of the most powerful element of

[17] Ritu Birla, "History and the Critique of Postcolonial Reason: Limits, Secret, Value", *Interventions* 4:2: 175-85, p. 181.

society, the state.[18] On the contrary, colonial civil society in British Malaya not only initiated and provided supplementary medical support, but also sought to determine overall directions of public health as well. Given such a relationship, it would be opportune to use health politics as a microcosm of the fabric of colonial civil society. Aside from re-looking at the narratives of players already featured in mainstream Malayan historiography, like plantation associations, merchant groups and anti-opium movements, the net of social medicine has also trawled in otherwise peripheral players like the Rockefeller Foundation and the social hygiene movements. Last but not least, the study of the activities of the health movements has as a whole facilitated the appreciation of the region's history within global forces.

A more important consideration for this project is to further historicise the role of civil societies in both Singapore and Malaysia. Emphasising its importance, Gillies found: "the determined efforts of various organisations and their leaders to use a variety of imaginative methods to overturn major British policy decisions...have clearly demonstrated that it was possible for civil society to exist within British power."[19] Nonetheless, while recognising the need to map out a more historicised study of state-society relationship, I strongly hesitate to share her positive acknowledgement of "civil society." Cautioning against such valorisation, John Hall and Frank Trentmann argue:

> It is unwise to view the concept of civil society through some sort of whiggish or evolutionary narrative of democratic perfection that advances with time. Most civil society ideas were developed as arguments about political societies and as such involved the state. Civil society could be utilised by[...]social movements to reinforce ideas of nation-state and imperial mission just as much as an emancipatory idea of checking the abuse of state power.[20]

Just as it is crucial not to see the state as a monolithic entity, civil society should not be regarded as an undifferentiated force. Being outside the state does not automatically presuppose these groups as vanguards of communitarian participation or watchdogs against political absolutism and tyranny. The health lobbies in British Malaya might have built charity medical facilities and unreservedly criticised public authority.

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[18] Joel Migdal. *State in Society: Studying how States and Societies Transform and Constitute One Another* (United Kingdom: Cambridge University Press, 2001) p. 106.
[19] Gillis. *Singapore Civil Society and British Power*. p. 73.
[20] John Hall and Frank Trentmann (eds). *Civil Society: A Reader in History, Theory and Global Politics* (New York: Palgrave, Macmillan, 2005) p.21

Nonetheless, their positions within colonial civil society were more chequered than the lionised roles that some of its players had perceived of themselves. Collectively, these stakeholders can be said to represent the upper echelons of colonial civil society, whose identities were defined not just by their wealth, but by access to political office and socio-cultural capital. Aside from participation in the formal arenas of the media, legislature and other government committees, the knowledge of the discourses of modern medical sciences also enabled these groups to effectively articulate their interests and to shape policies.

Despite unreserved public criticisms of the local administration, health lobbies never questioned the legitimacy of British hegemony in Malaya on which their privileges were founded. Moreover, although concerned with the health and welfare of the subaltern populace from villagers to prostitutes and coolies, enfranchising and mobilising them politically were never the agendas of these interest groups. Instead, the merchants, planters, IHB officials, medical missionaries and abolitionists had generally portrayed the Malayan populace as being backward and helpless, needing to be saved from themselves. To Philip Wagoner, such groups would have been the "active agents of colonising society, operating upon the passive patients of the colonised[...]leading to more effective consolidation of political power."[21] Even for the relatively more radical factions of the health movements, the culture of colonial paternalism was still prevalent in their social reforms. Calls for healthier and more dignified working and living environments did not mean greater political empowerment and representation for the colonised. On the contrary, the discourse of modern medicine to these health lobbies served more to demonstrate the magnanimity and hegemony of the privileged colonial elite.

In the words of Manderson, this language of science of medicine provided "the intellectual legitimacy to the domination of one people over others."[22] However, she saw such tentacles stretching predominately from the bureaucratic octopus of the colonial state instead of colonial civil society as a whole. In many respects, the work of these health lobbies paralleled what Bernard Cohn explains as the investigative

[21] Philip B. Wagoner. "Pre-colonial Intellectuals and the Production of Colonial Knowledge", *Comparative Studies in History and Society* 45(4). October 2003: 783-814. p. 784.
[22] Manderson. *Sickness and the State*. p. 242.

modality of the colonial state in the collection of a body of information through which appropriate knowledge is gathered, ordered and classified.[23] What is more important to note is regardless of their differences, these organisations operated within the consensus of the primacy of British Imperial domination and colonial modernity in Malaya. In sum, the featured health lobbies occupied and represented the more conservative and elite sections of colonial society.

The trade and plantation associations, international health organisations, medical missions and the abolitionists dominated the public limelight in the social and official circles of colonial society. But, their relevance was dwarfed by emerging radical forces like trade unions, nationalist and revolutionary parties which transformed the political configurations in British Malaya.[24] Increasingly, by the late 1940s where Britain, in the words of A.J. Stockwell, had a "mental revolution" with " decolonisation [entering] the official mind...",[25] these health lobbies became rapidly archaic in a radically changing political landscape from colonial hegemony to the rule of the nationalist party-states.

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[23] Bernard Cohn. *Colonialism and its Forms of Knowledge. The British in India* (New Jersey: Princeton University Press, 1996) pp. 3-15.

[24] See: Marc Frey, Ronald W. Pruessen, and Tan Tai Yong (eds). *The Transformation of Southeast Asia: International Perspectives on Decolonisation* (Armonk, N.Y. : M.E. Sharpe, 2003). Leong Yee Fong. *Labour and Trade Unionism in Colonial Malaya: A Study of the Socio-Economic and Political Bases of the Malayan labour movement, 1930-1957* (Pulau Pinang : Penerbit Universiti Sains Malaysia , 1999). Harper. *The End of Empire and the Making of Malaya.* Anthony Milner. *The Invention of Politics in British Malaya: Contesting Nationalism and Expansion of the Public Sphere* (Cambridge: Cambridge University Press, 1994). William Roff. *The Origins of Malay Nationalism* (Kuala Lumpur: Oxford University Press, 1994). Ingelise Lamont Lanman. *The Fabric of Malay Nationalism on the Malay Peninsula, 1920-40* (PhD Thesis: University of California, Los Angeles, 1988). Yeh Ching Hwang. *Overseas Chinese Nationalism in Singapore and Malaya, 1877-1912* (Centre for Asian Studies, University of Adelaide, Australia, 1979).

[25] A.J. Stockwell , "British Imperial Policy and Decolonisation in Malaya, 1942-52", Paul Kratoska. *Colonial History: Volume 5* (London, New York, Routledge, 2001) p.226.

Annex A: Appendix 1: Tables in Chapter One

Contents:

Table 1: Quarantine Centres in the Straits Settlements

Year	No of ships inspected	No of passengers screened	No of passengers retained
1926	1,535	480,346	65,923
1927	2,556	1,010,249	109,018
1928	1,821	758,516	57,266
1929	2,130	788,525	142,094
1930	1,666	647,142	83,046
1931	1,072	342,045	15,275
1932	1,561	241,277	31,639
1933	1,315	254,297	35,722
1934	1,082	391,982	2,021
1935	1,179	415,540	55,141
1936	1,421	428, 118	27,918
1937	1,205	428,194	71,505

Source: Compilation of data from *SSAR*.

Table 2: Activities of the Quarantine Station in Penang from 1906-1917

Year	Total Inmates	Daily Average Inmates	Cholera treated	Plague treated	Smallpox treated	Vaccination performed	Total deaths	Percentage of deaths
1906	23,288	461	8	2	16	6,490	34	0.14
1907	17,650	116	24	1	4	5,652	38	0.21
1908	21,175	366	9	2	51	5,691	18	0.08
1909	23,058	359	2	1	25	5,614	10	0.04
1910	71,876	1,584	33	2	62	12,205	98	0.13
1911	134,957	3,740	387	1	109	63,988	656	0.48
1912	55,493	1,111	4	4	75	38,297	61	0.01
1913	53,937	120	12	1	11	37,276	45	0.08
1914	48,399	116	9	-	171	32,609	131	0.27
1915	23,176	478	-	-	3	21,562	11	0.04
1916	42,736	817	1	-	11	36,806	17	0.03
1917	37,595	820	12	-	11	36,808	30	0.13

Source: *SSAR, 1917*, Statement B, p. 77

Table 3: Public Health Expenditure of the Straits Settlements

Year	Medical Expenditure	Hospitals and Dispensaries	Total Medical Expenditure	Total Expenditure	Total Revenue	Percentage of Total
1883	77,443		77,443	3,310,095	3,059,342	2.33
1884	93,911		93,911	3,238,031	3,515,841	2.90
1885	102,907		102,907		3,508,075	
1886	106,014		106,014	3,495,639	3,747,501	3.03
1887	117,157		117,157	3,511,096	3,847,475	3.37
1888	116,113		116,113	3,559,864	3,858,909	3.26
1889	131,194		131,194	3,816,194	4,410,620	3.44
1890	139,811		139,811	3,757,693	4,269,125	3.72
1891	138,655		138,655	4,598,978	3,826,603	3.01
1892	145,906		145,906	4,266,407	3,652,789	3.42
1893	151,571		151,571	3,195,482	3,703,608	4.74

1894	148,989		148,989	3,714,620	3,904,774	4.01
1895	168,211		168,211	3,782,456	4,048,360	4.45
1896	185,338		185,338	3,957,262	4,266,064	4.68
1897	167,074		167,074	4,429,694	4,320,207	3.77
1898	173,522		173,522	4,587,366	5,071,281	3.78
1899	184,926		184,926	5,062,229	5,200,026	3.65
1900	193,551		193,551	6,038,790	5,386,927	3.20
1901	195,422		195,422	7,315,001	7,041,595	2.67
1902	206,602		206,602	7,600,734	7,754,736	2.72
1903	257,302		257,302	8,185,952	7,958,496	3.14
1904	260,804		260,804	11,134,865	10,629,329	2.34
1905	234,198		234,198	11,005,137	11,656,153	2.13
1906	246,821		246,821	9,333,901	9,618,314	2.64
1907	253,025		253,025	9,499,602	10,023,016	2.66
1908	593,270		593,270	9,837,624	8,920,346	6.03
1909	608,537		608,537	8,542,731	8,795,001	7.12
1910	238,102	374,950	613,052	7,532,242	9,336,328	8.15

1911	186,649	355,308	541,957	9,085,389	11,409,221	5.97
1912	221,735	365,736	587,471	9,295,102	12,912,577	6.32
1913	252,370	365,746	618,116	10,468,618	12,397,747	5.90
1914	250,008	459,972	709,980	10,180,189	14,016,882	6.97
1915	245,775	525,726	771,501	10,196,560	14,131,691	7,57
1916	236,418	448,432	684,850	11,046,353	17,325.695	6.12
1917	257,865	552,211	810,076	11,369,392	19,672,104	7.13
1918	256,626	556,814	813,440	15,996,145	23,262,015	5.01
1919	286,319	784,992	1,071,311	34,901,233	34,108,465	3.07
1920	465,380	1,085,784	1,551,164	39,260,318	42,469,620	3.95
1921	570,576	1,411,802	1,982,378	35,430,899	39,545,735	5.60
1922	518,471 (M) 23,262 (MS) 132,575 (H)	1,189,423	1,863,731	24,797, 085	34,103,462	7.52
1923	434,248 (M) 228,692 (H)	1,119,612	1,782,552	26,717,778	33,316,015	6.67
1924	384,476 (M) 262,126 (H)	1,363,612	2,010,214	26,706,316	28,639,161	7.53
1925	436,980 (M) 393,458 (H)	1,585,702		**57,593,959?**	**25,211,799**	
1926	462,081 (M) 511,289 (H)	1,973,157	2946527	36,955,640	36,465,213	7.98

1927	401,677 (M) 604,635 (H) 92,488 (SH)	2,066,543	3,165,343	39,252,272	37,602,081	8.01
1928	360,311 (M) 648,914 (H) 98,620 (SH)	2,246,130	3,353,975	35,007,608	38,604,536	8.54
1929	348,581(M) 627,620 (H) 99,033 (SH)	2,248,416	3,232,650	35,711,996	54,888,290	9.31
1930	468,412 (M) 681,381(H) 116,687 (SH)	2,349,760	3,616,240	39,240,314	32,408,305	9.22
1931	452,919 (M) 717,479 (H) 125, 724(SH)	2,443,878	3,740,000	46,802,558	26,601,527	8.00
1932	480,826 (M) 717,479 (H) 110,293 (SH)	2,156,868	3,465,466	34,196,482	44,562,294	10.13
1933	457,989 (M) 528,725 (H) 94,119 (SH)	2,023,176	3,104,009	30,476,290	31,585,190	10.18
1934	371,183(M) 504,157 (H) 92,940 (SH)	2,141,655	3,109,935	30,937,261	34,244,603	10.05
1935	369,730 (M) 539,752 (H) 91,658 (SH)	2,241,750	3,242,890	34,764,640	35,040,380	9.33
1936	407,299 (M) 560,146 (H) 102,822 (SH)	2,310,389	3,380,656	33,398,912	35,124,137	10.12
1937	421,691(M) 570,984 (H) 99,273 (SH)	2,425,599	3,517,547	42,038,481	37,348,383	8.37

1938	441,054 (M) 739,858 (H) 104,530 (SH)	4,698,115	5,983,557	69,955,265		8.55
1939	528,591(M) 801,376(H) 114,518 (SH)	3,137,896	4,582,381	55,621,267		8.24
1940	530,840 (M) 853,864 (H) 111,087 (SH)	3,306,547	4,802,338	45,261,271	35,061,271	10.61
1941	560, 412 (M) 850,074 (H) 124,104 (SH)	3,773,180	5,307,770	60,503,398		8.77

Source: Compilation of Estimated Revenue and Expenditure figures *SSAR*, 1883-1941.
Includes expenditure of Health Branch from 1922. H: Health Branch, MS: Medical and Sanitary Services, SH: Social Hygiene

Table 4: Layout of Malaya Medical Services, 1936

Super-scale appointments					**No**
Director of Medical Services, Straits Settlements and Adviser, Medical Service Federated Malay States					01
Deputy Director of Medical Service, Straits Settlements					01
Grade B: Medical & Health Appointments	**No**	**The Institute for Medical Research**	**No**	**College of Medicine, Singapore**	**No**
Chief Health Officer, Singapore	01	Directors	02	The Principal	01
Chief Medical Officer, Singapore	01	Pathologists	02	The Professors:	
Chief Medical Officer, Penang	01	Malaria Research Officers	02	Physiology	01
State Medical and Health Officers of Perak, Selangor, Negri-Sembilan and Pahang	04	The Entomologist	01	Bacteriology,	01
		The Chief Chemist	01	Medicine, Surgery,	01
		Three Chemist	01	Midwifery, Anatomy,	01
		Research Students	02	Pathology, Clinical	01
				Surgery, Biology,	01
				Biochemistery	01
				Dental Surgery.	01
				The Dental Officer	01
				and Lecturer in	01
				Dental Mechanics	01
Super-scale Specialist Appointment					

The pathologist: Straits Settlements and Professor of Pathology, College of Medicine (Grade A) The Surgeon, Singapore: Grade B The Surgeon, Penang, Grade B The Surgeon, Perak, Grade B The Surgeon, Selangor, Grade B The Ophthalmic Surgeon and Physician, Singapore, Grade B The Radiologist, Singapore Grade B The Chief Medical Officer, Social Hygiene, Straits Settlements, Grade B The Physician and Registrar, General Hospital, Grade B The Medical Superintendent, Central Mental Hospital, Tanjong Rambutan, Perak, Grade B The Medical Superintendent, Mental Hospital, Singapore, Grade B	01 01 01 01 01 01 01 01 01 01 01	

Time Scale and Health Appointments	Nos
Medical officers, Straits Settlements	10
Medical Officers, Federated Malay States: 16	16 04
Lady Medical Officers, Straits Settlements	08
Lady Medical Officers, Federated Malay States	05 15
Health Officers, Straits Settlements	
Health Officers, Federated Malay states:	
Nursing Staff	
Matrons (Straits Settlements: 9, Federated Malay States: 11)	30 97
Nursing Sisters (Straits Settlements: 63, Federated Malay States: 34	12
Health Matrons and Sisters (Straits Settlements: 5, Federated Malay States: 7	

Source: *Annual Report of the Medical Department, Straits Settlements and the Federated Malay States*, 1936, pp. 902-03.

Table 5: Distribution of Medical Facilities in relation to Population

	Singapore	Penang	Province Wellesley	Malacca	Perak	Selangor	N. Sembilan	Pahang	Total
Population (Total)	603,163	205,944	148,405	202,828	830,093	575,775	249,853	192,230	3,008,341
Main Hospitals	3	3	3	1	14	7	6	6	43
Beds	1,753	680	400	500	2,312	1,475	966	1,980	10,066
Estate population	2,200	680	7,014	17,746	80,890	91,000	49,363	15,714	264,607
Estate Hospitals	Nil	Nil	4	15	47	41	31	13	151
Beds in estate hospitals	Nil	Nil	220	540	1,410	2,966	1,293	395	6,429
Travelling motor dispensaries	1	1	1	2	8	4	5	4	26
Outdoor dispensaries	5	1	1	2	19	12	4	8	59
River Dispensaries	Nil	Nil	Nil	Nil	2	Nil	Nil	1	3
Infant welfare Centres	5	6	6	10	3	9	1	3	43

Source: Compilation of data from *SSAR*, 1938, pp. 904-909

Table 6: Population Distribution in British Malaya

Straits Settlements	Area (sq miles)	Total Population	European	Malay	Chinese	Indian	Others
Singapore	220	727,564	11,412	73,940	565,182	59,815	16,215
Penang	110	239,742	1,937	41,155	160,151	32,359	4,140
P. Wellesley	290	165,960	291	76,010	60,139	28,668	852
Malacca	640	228,307	436	108,789	87,778	28,224	3,053
Labuan	35	8,717	29	5,300	3,128	150	110
Total Straits Settlements	**1,295**	**1,370,290**	**14,132**	**304,194**	**876,378**	**149,216**	**25,370**
Perak	7,980	954,084	3,232	321,625	427,392	194,998	6,837
Selangor	3,160	672,459	3,918	145,500	320,803	191,750	10,488
Negri Sembilan	2,580	285,976	1,115	102,271	119,918	59,259	3,413
Pahang	13,820	212,755	492	124,339	69,333	17,132	1,459
Total Federated Malay States	**27,540**	**2,125,274**	**8,757**	**693,735**	**937,446**	**463,139**	**22,197**
Johore	7,878	637,052	961	282,291	291,093	58,342	4,365
Kedah	3,648	506,597	526	328,657	102,938	60,645	13,831
Kelantan	5,870	397,499	162	359,886	22,287	7,688	7,476
Trengganu	5,000	200,708	41	182,389	16,190	1,413	675
Perlis	310	55,650	3	44,678	7,876	1,095	1,998
Brunei	2,500	37,205	96	30,949	4,988	381	791
Total Unfederated Malay States	**25,260**	**1,834,711**	**1,789**	**1,228,850**	**445,372**	**129,564**	**29,136**
Total: Malaya	**54,041**	**5,330,275**	**24,678**	**2,227,779**	**2,259,196**	**741,919**	**76,703**

Source: PRO/CO273/662/6Memorandum on the state of public health in Malaya Medical Report 1939

Table 7: Distribution of Health Officers in the Unfederated Malay States, 1937

Malay States	Area (square miles)	Residents	Medical/Health Officials	Dental officers
Johore	7,878	613,510	27	3
Kedah	3,684	474,800	8 (with Perlis)	1
Perlis	310	52,700		Nil
Kelantan	5,870	400,378	3	Nil
Trengganu	5,000	198,246	2	Nil

Source: *Annual Medical Report, Straits Settlements and Federated Malay States*, 1937, p. 996

Table 8:Hospital Admission Rates the Straits Settlements, Federated Malay States and the Unfederated Malay States, 1939

Hospital Admissions	Total Population	Males	Females	Children	Total Admissions	% of total population
Straits Settlements						
Singapore						
Penang	727,564	22,640	11,755	3,519	37,914	5.2%
Malacca	405,702	13,880	7,029	1,881	22,790	5.6%
Labuan	228,307	5,768	2,516	1,678	9,962	4.4%
	8,717	204	42	25	271	3.1%
Total:	**1,370,290**	**42,492**	**21,342**	**5,425**	**70,937**	**5.2%**
Federated Malay States						
Perak						
Selangor	954,084	32,645	14,565	5,549	52,758	5.6%
N.Sembilan	672,459	21,776	8,258	2,987	33,021	4.9%
Pahang	285,976	13,921	5,764	2,418	22,103	7.7%
	212,755	13,824	5,875	2,468	23,167	10.9%
Total:	**2,125,274**	**82,166**	**34,462**	**13,422**	**131,049**	**6.11%**
Unfederated Malay States						
Johore						
Kedah	637,052	33,234	11,909	5,549	54,403	8.5%
Kelantan	506,597	14,790	4,148	2,987	21,923	4.3%
Trengganu	397,499	4,440	895	2,418	5,633	1.4%
	200,708	3,701	451	3,468	4,341	2.2%
Total	**1,741, 856**	**56.165**	**17,403**	**14,422**	**86,300**	**5.0%**
Total Malaya	**5,237,420**	**180,823**	**73,270**	**33,269**	**288,286**	**5.5%**

Source: PRO/CO273/662/6.Memorandum on the state of public health in Malaya Medical Report 1939.

Table 9: Attendances in Outpatient and Infant Welfare Centres

Territories	Outpatient Attendances	Infant Welfare Centres
Singapore	349,439	84,829
Penang	365,650	89,255
Malacca	138,440	20,726
Labuan	11,050	8,168
Total Straits Settlements	**864,679**	**202,978**
Perak	530,848	55,360
Selangor	484,905	69,461
N.Sembilan	158,003	30,513
Pahang	267,551	59,760
Federated Malay States Total	**1,441,307**	**188,094**

Source: S.S.A.R, 1938.

Table 10. Comparative statement showing the number of patients treated at the Government Outdoor Dispensary, Penang, 1895-1905

Year	Number of patients attended	Number of visits paid	Free treatment	Pauper patients	Average visits per diem	Number of days dispensary opened	Paying patients	Receipts
1895	4,471	10,112	1,258	423	32.72	309	2,790	$861.00
1896	5,471	12,274	1,649	302	39.85	308	3,466	$824.20
1897	5,563	12,287	1,537	414	41.37	297	3,612	$845.20
1898	5,732	11,912	1,625	329	39.83	299	3,778	$871.35
1899	4,141	8,698	995	218	29.55	264	2,928	$679.85
1900	4,320	8,076	1,014	190	27.56	293	3,116	$684.30
1901	4,286	7,904	1,214	218	26.70	296	2,854	$617.1 0
1902	4,894	8,269	1,700	170	27.80	296	3,024	$643.40
1903	4,909	9,709	1,500	160	32.69	297	3,249	$643.40
1904	5,826	11,860	2,026	252	39.53	300	3,548	$795.10
1905	6,504	11,259	2,624	218	38.16	295	3,662	$840.56

Source: *SSMR*, 1905, p. 63

Table 11: Vaccinations performed in the Federated Malay States 1924-7

States	1924	1925	1926	1927
Perak	54,278	86,125	88,539	106,865
Selangor	11,745	26,369	14,256	65,091
Negri-Sembilan	6,563	8,268	5,392	64,639
Pahang	5,821	5,543	5,727	32,914
Total	**78,407**	**126,305**	**113,914**	**269,509**

Source: *FMSAR*, 1927. p. 30.

Table 12: Hospital Admissions in the Straits Settlements based on Diseases, 1899-1929

Year	Malaria	Dysentery	Diarrhoea	Beri Beri	Phthisis and Tuberculosis	Enteric	Ulcers	Venereal Diseases	Ankylostomiasis
1899	2,336 (Treated)	913 (Treated)	NA	1,793 (Treated)	644 (Treated)	NA	NA	2,523 (Treated)	NA
	313 (Deaths)	313 (Deaths)		589 (Deaths)	343 (Deaths)	NA	NA	88 (Deaths)	NA
1900	2,753 (Treated)	1,070 (Treated)	NA	2,177 (Treated)	784 (Treated)	NA	NA	1,952 (Treated)	NA
	233 (Deaths)	280 (Deaths)		620 (Deaths)	440 (Deaths)	NA	NA	110 (Deaths)	NA
1901	2,290 (Treated)	800 (Treated)	NA	1,817 (Treated)	904 (Treated)	NA	NA	2,341 (Treated)	NA
	153 (Deaths)	300 (Deaths)		697 (Deaths)	514 (Deaths)	NA	NA	90 (Deaths)	NA
1902	2,938 (Treated)	866 (Treated)	NA	1,901 (Treated)	699 (Treated)	NA	NA	3,149 (Treated)	NA
	277 (Deaths)	262 (Deaths)		575 (Deaths)	355 (Deaths)	NA	NA	**101(Deaths)**	NA
1903	2,005 (Treated)	707 (Treated)	NA	1,919 (Treated)	730 (Treated)	NA	NA	1,818 (Treated)	NA
	151 (Deaths)	267 (Deaths)		647 (Deaths)	408 (Deaths)	NA	NA	96 (Deaths)	NA
1904	2,694 (Treated)	723 (Treated)	NA	2,631 (Treated)	853 (Treated)	NA	NA	1,784 (Treated)	NA
	205 (Deaths)	245 (Deaths)		879 (Deaths)	484 (Deaths)	NA	NA	95 (Deaths)	NA
1905	2,778 (Treated)	1,088 (Treated)	NA	1,958 (Treated)	882 (Treated)	NA	NA	2,105 (Treated)	NA
	300 (Deaths)	405 (Deaths)		575 (Deaths)	533 (Deaths)	NA	NA	88 (Deaths)	NA
1906	2,859 (Treated)	1,668 (Treated)	NA	1,712 (Treated)	984 (Treated)	NA	NA	2,371 (Treated)	NA

	254 (Deaths)	426 (Deaths)		296 (Deaths)	571(Deaths)	Na	NA	50 (Deaths)	NA
1907	4,279 (Treated)	1,351 (Treated)	NA	1,559 (Treated)	NA	NA	NA	2,589 (Treated)	NA
	395 (Deaths)	540 (Deaths)		243 (Deaths)	NA			48 (Deaths)	NA
1908	4,587 (Treated)	1,452 (Treated)	909 (Treated)	2,777 (Treated)	1,032 (Treated)	243 (Treated)	2,116	2,114 (Treated)	NA
	504 (Deaths)	658 (Deaths)	229 (Death)	284 (Deaths)	601 (Deaths)	96 (Deaths)	0	55 (Deaths)	NA
1909	5,183 (Treated)	1,743 (Treated)	714 (Treated)	2,118 (Treated)	1,080 (Treated)	316 (Treated)	2,807 (Treated)	2,603 (Treated)	NA
	331 (Deaths)	670 (Deaths)	126 (Deaths)	224 (Deaths)	541 (Deaths)	79 (Deaths)	19 (Deaths)	49 (Deaths)	NA
1910	7,312 (Treated)	1,643 (Treated)	824 (Treated)	2,044 (Treated)	1,103 (Treated)	113 (Treated)	**2,807 (Treated)**	2,209 (Treated)	NA
	687 (Deaths)	689 (Deaths)	159 (Deaths)	290 (Deaths)	554 (Deaths)	47 (Deaths)	08 (Deaths)	42 (Deaths)	NA
1911	12,029 (Treated)	2,268 (Treated)	1,146 (Treated)	2,152 (Treated)	1,095 (Treated)	186 (Treated)	4,359 (Treated)	2,789 (Treated)	619 (Treated)
	1,014 (Deaths)	996 (Deaths)	332 (Deaths)	242 (Deaths)	576 (Deaths)	102 (Deaths)	03 (Deaths)	40 (Deaths)	150 (Deaths)
1912	9,474 (Treated)	1,845 (Treated)	940 (Treated)	2,032 (Treated)	1,111 (Treated)	133 (Treated)	4,232 (Treated)	3,522 (Treated)	919 (Treated)
	660 (Deaths)	654 (Deaths)	235 (Deaths)	293 (Deaths)	564 (Deaths)	63 (Deaths)	03 (Deaths)	39 (Deaths)	173 (Deaths)
1913	8,314 (Treated)	1,479 (Treated)	1,479 (Treated)	2,045 (Treated)	1,014 (Treated)	157 (Treated)	3,320 (Treated)	3,216 (Treated)	1,073 (Treated)
	499 (Deaths)	516 (Deaths)	516 (Deaths)	187 (Deaths)	493 (Deaths)	56 (Deaths)	04 (Deaths)	50 (Deaths)	159 (Deaths)
1914	8,129(Treated)	1,470 (Treated)	720 (Treated)	1,764 (Treated)	1,226 (Treated)	142 (Treated)	3,226 (Treated)	3,472 (Treated)	1,131 (Treated)

	528 (Deaths)	530 (Deaths)	127 (Deaths)	183 (Deaths)	575 (Deaths)	67 (Deaths)	02 (Deaths)	34 (Deaths)	174 (Deaths)
1915	5,590 (Treated)	1,267 (Treated)	526 (Treated)	940 (Treated)	1,162 (Treated)	100 (Treated)	2,743 (Treated)	4,124 (Treated)	1,002 (Treated)
	311 (Death)	407 (Deaths)	50 (Deaths)	92 (Deaths)	551 (Deaths)	44 (Deaths)	02 (Deaths)	56 (Deaths0	141 (Deaths)
1916	7,584 (Treated)	1,230 (Treated)	447 (Treated)	755 (Treated)	1,127 (Treated)	108 (Treated)	2,617 (Treated)	3,360 (Treated)	1,255 (Treated)
	564 (Deaths)	405 (Deaths)	61 (Deaths)	104 (Deaths)	519 (Deaths)	31 (Deaths)	01 (Deaths)	80 (Deaths)	214 (Deaths)
1917	7,355 (Treated)	1,516 (Treated)	431 (Treated)	1,520 (Treated)	1,214 (Treated)	116 (Treated)	2,323 (Treated)	3,232 (Treated)	1,526 (Treated)
	613 (Deaths)	563 (Deaths)	28 (Deaths)	299 (Deaths)	594 (Deaths)	42 (Deaths)	01 (Deaths)	82 (Deaths)	268 (Deaths)
1918	7,726 (Treated)	2,481 (Treated)	407 (Treated)	1,725 (Treated)	1,337 (Treated)	251 (Treated)	2,432 (Treated)	2,774 (Treated)	1,714 (Treated)
	766 (Deaths)	739 (Deaths)	41 (Deaths)	283 (Deaths)	692 (Deaths)	106 (Deaths)	02 (Deaths)	101 (Deaths)	385 (Deaths)
1919	6,446 (Treated)	1,708 (Treated)	420 (Treated)	1,556 (Treated)	1,442 (Treated)	142 (Treated)	3,196 (Treated)	3,451 (Treated)	1,183 (Treated)
	472 (Deaths)	632 (Deaths)	35 (Deaths)	236 (Deaths)	686 (Deaths)	63 (Deaths)	01 (Deaths)	77 (Deaths)	241 (Deaths)
1920	7,539 (Treated)	1,451 (Treated)	460 (Treated)	363 (Treated)	1,450 (Treated)	167 (Treated)	4,027 (Treated)	3,836 (Treated)	1,501 (Treated)
	548 (Deaths)	462 (Deaths)	23 (Deaths)	43 (Deaths)	698 (Deaths)	61 (Deaths)	05 (Deaths)	52 (Deaths)	312 (Deaths)
1921	7,681 (Treated)	1,452 (Treated)	451 (Treated)	684 (Treated)	1,500 (Treated)	174 (Treated)	4,169 (Treated)	4,319 (Treated)	1,944 (Treated)
	567 (Deaths)	490 (Deaths)	23 (Deaths)	184 (Deaths)	717 (Deaths)	86 (Deaths)	03 (Deaths)	44 (Deaths)	278 (Deaths)
1922	6,989 (Treated)	1,497 (Treated)	390 (Treated)	1,175 (Treated)	1,552 (Treated)	116 (Treated)	3,552 (Treated)	4,421 (Treated)	2,155 (Treated)
	394 (Deaths)	605 (Deaths)	09 (Deaths)	168 (Deaths)	722 (Deaths)	45 (Deaths)	09 (Deaths)	140 (Deaths)	163 (Deaths)

1923	5,297 (Treated)	1,566 (Treated)	485 (Treated)	962 (Treated)	1,714 (Treated)	92 (Treated)	2,577 (Treated)	4,194 (Treated)	2,508 (Treated)
	376 (Deaths)	454 (Deaths)	22 (Deaths)	28 (Deaths)	789 (Deaths)	39 (Deaths)	02 (Deaths)	56 (Deaths)	124 (Deaths)
1924	5,135 (Treated)	1,387 (Treated)	544 (Treated)	838 (Treated)	1,778 (Treated)	93 (Treated)	2,618 (Treated)	4,362 (Treated)	1,887 (Treated)
	312 (Deaths)	373 (Deaths)	41 (Deaths)	136 (Deaths)	849 (Deaths)	37 (Deaths)	10 (Deaths)	145 (Deaths)	120 (Deaths)
1925	7,042 (Treated)	1,296 (Treated)	696 (Treated)	995 (Treated)	1,966 (Treated)	159 (Treated)	3,357 (Treated)	4,721 (Treated)	4,499 (Treated)
	429 (Deaths)	366 (Deaths)	67 (Deaths)	150 (Deaths)	819 (Deaths)	78 (Deaths)	02 (Deaths)	109 (Deaths)	123 (Deaths)
1926	14,293 (Treated)	1,987 (Treated)	928 (Treated)	1,228 (Treated)	1,964 (Treated)	258 (Treated)	4,795 (Treated)	5,371 (Treated)	4,322 (Treated)
	984 (Deaths)	575 (Deaths)	89 (Deaths)	221 (Deaths)	853 (Deaths)	85 (Deaths)	04 (Deaths)	115 (Deaths)	174 (Deaths)
1927	15,426 (Treated)	1,561 (Treated)	1,412 (Treated)	1,786 (Treated)	1,941 (Treated)	302 (Treated)	3,266 (Treated)	4,983 (Treated)	4,012 (Treated)
	949 (Deaths)	511 (Deaths)	158 (Deaths)	361 (Deaths)	952 (Deaths)	132 (Deaths)	05 (Deaths)	95 (Deaths)	102 (Deaths)
1928	13,181 (Treated)	1,418 (Treated)	856 (Treated)	1,499 (Treated)	1,866 (Treated)	347 (Treated)	5,392 (Treated)	4,402 (Treated)	3,037 (Treated)
	932 (Deaths)	856 (Deaths)	123 (Deaths)	236 (Deaths)	920 (Deaths)	145 (Deaths)	05 (Deaths)	151 (Deaths)	84(Deaths)
1929	11,036 (Treated)	1,167 (Treated)	963 (Treated)	1,322 (Treated)	2,080 (Treated)	214 (Treated)	3,994 (Treated)	4,445 (Treated)	2,827 (Treated)
	784 (Deaths)	306 (Deaths)	143 (Deaths)	175 (Deaths)	910 (Deaths)	78 (Deaths)	12 (Deaths)	110 (Deaths)	63 (Deaths)

Source: Compilation of Hospital Admissions from Straits Settlements Annual Medical Reports between: 1899 to 1929..

Table 13:Zymotic Diseases in Singapore 1892-1927

Year	Plague		Cholera		Smallpox	
	Cases	Deaths	Cases		Cases	Deaths
1892	-	-	-		-	-
1893	-	-	07		-	-
1894	-	-	01		-	-
1895	-	-	430		-	-
1896	-	-	592		-	-
1897	-	-	54		-	-
1898	-	-	07		-	-
1899	-	-	03		03	316
1900	01	01	224		194	197
1901	16	14	133		120	47
1902	04	03	842		727	159
1903	03	03	226		184	109
1904	20	18	03		03	33
1905	19	19	16		15	20
1906	10	10	191		171	33
1907	15	15	205		187	08
1908	12	11	133		127	27
1909	5	5	82		77	41
1910	5	5	132		130	415
1911	35	32	235		235	254
1912	37	33	121		114	59
1913	01	01	97		79	19
1914	16	13	274		211	13
1915	37	33	09		05	18
1916	26	23	13		08	70
1917	51	44	08		07	33
1918	229	204	03		03	11

Year Cases	Plague		Cholera		Smallpox		
	Cases	Deaths	Cases	Deaths	Cases		Deaths
1919	19	06	75	58	14		03
1920	61	55	33	32	04		02
1921	28	27	01	01	150		33
1922	39	39	01	01	268		58
1923	59	55	-	-	36		03
1924	20	18	11	06	05		01
1925	59	53	02	02	02		02
1926	04	-	21		-	34	-
1927	-	-	-		-	-	-

Source: *SSAR*, 1927. p.737.

Table 14: Crude Death, Birth and Infant Mortality Rates for the Straits Settlements, 1901-1937

Year	Death per 1,000	Birth per 1,000	Infant Mortality Rate	Year	Death per 1,000	Birth per 1,000	Infant Mortality Rate
1901	39.85	25.46	230.26	1920	33.20	30.29	194.86
1902	42.96	24.98	246.59	1921	31.54	29.63	179.23
1903	39.49	26.35	245.06	1922	30.68	30.59	195.22
1904	39.00	25.59	250.05	1923	27.80	30.43	200.73
1905	40.51	28.57	256.29	1924	27.42	32.29	194.57
1906	37.82	25.23	255.02	1925	27.26	31.98	194.00
1907	39.07	26.11	250.91	1926	31.81	32.85	214.79
1908	43.06	28.75	265.63	1927	33.55	35.13	224.04
1909	37.58	26.69	263.67	1928	36.03	36.03	193.69
1910	41.88	27.55	268.93	1929	26.10	27.20	188.61
1911	46.46	25.38	270.47	1930	27.32	38.25	200.19
1912	39.01	28.26	267.21	1931	24.47	26.98	185.15
1913	34.93	28.87	271.34	1932	21.39	35.83	166.42
1914	34.13	29.09	250.23	1933	24.26	40.95	172.72
1915	29.15	29.25	236.68	1934	26.54	40.65	175.43
1916	30.70	28.15	216.72	1935	25.11	41.76	165.28
1917	36.98	30.65	266.92	1936	24.91	44.33	170.85
1918	43.85	28.64	232.38	1937	22.45	42.13	155.80
1919	33.04	30.29	212.42				

Source: *S.S.A.R*, 1937, p. 182 (also used in Manderson: Sickness and the State, p. 44).

Annex A, Appendix 2: Tables in Chapter 3

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Table:15. British Malaya's Estate Population

Territory	No of Estates	Persons	Males	Females	Europeans	Chinese	Indians
Singapore	13	6,989	4,090	2,989	18	4,923	1,181
Penang	56	19,099	10,676	8,423	105	1,735	14,688
Malacca	54	17,193	11,149	6,044	118	2,550	14,129
Straits Settlements	**123**	**48,281**	**25,915**	**17,366**	**241**	**9,208**	**29,998**
Perak	297	85,954	52,007	33,947	585	7,171	75,362
Selangor	281	96,592	57,986	38,606	659	6,363	87,776
Negri Sembilan	215	56,579	41,837	14,742	414	20,158	33,799
Pahang	48	12.367	8,407	3,960	77	3,811	6,099
Federated Malay States	**841**	**251,492**	**160,237**	**91,255**	**1,735**	**37,863**	**203,036**
Johore	269	73,306	56,720	16,586	390	30,922	32,036
Kedah	141	48,845	29,888	18,957	286	6,089	35,743
Kelantan	24	5,773	3,973	1,800	51	1,092	2,944
Trengganu	1	758	690	68	4	667	8
Perlis	2	396	238	158	-	76	301
Brunei	4	1,138	664	474	10	88	91
British Malaya	**1,405**	**424,989**	**278,325**	**146,664**	**2,717**	**86,005**	**304,157**

Source: *British Malaya. Report of the Census of 1931.* p. 159

Table: 16 Mortality of Free Indian Estate Labour, Federated Malay States

Year	Deaths	Average Population	Death rates per 1000
1902	106	3,233	32.8
1903	248	7,488	33.1
1904	187	9,869	18.9
1905	388	12,064	32.2
1906	1,400	24,225	57.8
1907	2,010	36,092	55.7
1908	3,322	45,514	68.6
1909	2,336	49,924	46.8
1910	3,204	73,147	43.8
1911	7,162	110,000	65.1
1912	5,014	122,000	41.1
1913	4,057	133,072	30.5
1914	3,695	128,506	28.8
1915	2,519	120,190	21.0
1916	2,860	129,964	22.0
1917	3,144	140,346	22.4
1918	7,786	144,719	53.8
1919	2,747	147,229	18.7
1920	3,910	162,535	24.1
1921	2,632	133,762	19.7
1922	2,194	123,849	17.7
1923	1,814	121,397	14.9
1924	1,430	119,754	11.9
1925	1,569	124,937	12.6
1926	2,573	164,651	15.6
1927	3,236	175,235	18.5
1928	2,684	170,824	15.7
1929	2,114	168,025	12.6
1930	2,047	163,591	12.5

Source: Complied by Shlomowitz and Brennan. "Mortality and Indian Labour in Malaya, 1877-1933, in *The Indian Economic and Social History Review*, 29,1 (1992) p.71

Table 17: Rate of mortality among Indian Labourers

Name of Estate	Average population	No of deaths	Death per mille
Perak			
Larut & Matang			
Noresman	161	5	31
Salamat	112	7	62
Subur	104	6	58
Witdene	121	5	33
Kuala Kangsar			
Heawood	317	20	63
Parit Perak	248	9	38
Sungei Krudds	229	10	45
Kinta Moynalpy	111	5	45
Batang Padang			
Bukit Basout	164	5	30
Hendra	130	11	85
Klapa Bali	114	4	35
Lower Perak			
Blenhemim	344	13	38
Sungei Timah	156	12	77
Selangor			
Inland Districts			
Batu	191	9	47.12
Batu Caves	497	17	34.20
Bukit Kiara	249	11	33.18
Bungsar	387	16	41.34
Elmina	532	32	60.15
Sungei Tua	227	11	48.45

Abaco	261	8	30.65
Benar	163	5	30.67
Bhutan	160	8	50.00
Dominion	176	11	62.50
Sydney	217	11	50.69
Bristol	419	22	52.50
Sungei Gapi	224	9	40.17
Sungei Dua	206	8	38.82
Utan Simpan	196	8	40.81
Coast District			
Ebor	131	6	45.80
Seafield	798	36	45.62
Sungei Nibong	146	9	61.64
Teah Bahru	131	6	45.80
Tremelbye	281	9	32.02
Vallambroasa	327	12	36.69
Braunston	476	34	71.42
Padang Gajah	389	19	48.84
Woodlake	134	5	37.31
Negri Sembilan			
Seremban District			
Ainsdale	103	4	38.7
Batu Sablas	113	6	53.1
Cairo	183	7	38.3
Carrotina	79	5	63.3
Hamilton	161	8	49.7
Jundaram	109	6	55.0
Kingsland	194	7	36.1
Kombok	303	18	59.4
Kubang	114	6	52.6
Mount Beryl	107	6	56.1
New Seremban	107	6	56.1

Old Seremban	131	13	99.2
Ribu	235	9	38.3
Sepang Valley	122	6	49.2
Sungei Mahang	163	8	49.1
Teiang Sungei Kaya	99	4	40.4
Terentang	251	11	43.7
Ulu Kanchong	117	6	51.3
Port Dickson			
Sungei Salak	204	7	34.3
Tampin	119	4	33.6
Ayer Angak	119	9	75.6
Pahang			
Batu Balai	100	7	70.00
Bents	237	8	33.75
Tung Moh	214	7	32.71
Cheroh	400	14	35.00
Gali	158	6	37.97
Mengkarak	205	7	34.14

Source: PRO/CO717/59/11. Submissions by Hugh Clifford on estates employing more than 100 people with death rates above 30 per mille, 3 January 1928

Table 18. List of Estate Hospitals in the Federated Malay States, 1918

Name of Estate	No of beds in hospital	Name of visiting/resident medical practitioner	Number of visits by visiting medical practitioners per month
Estate hospitals served by a Resident Medical Practitioner			
Kent (Selangor)	125	Dr Quaife	
Heawood Joint (Perak North)	39	Dr Scott	
Taiping Rubber Plantation (Perak North)	40	Dr Dixon	
Sungkai Planters (Lower Perak)	184	Dr Ward	
Bagan Datoh (Lower Perak)	40	Dr Hancock	
Sungei Wangi (Lower Perak)	64	Dr Aiyer	
Labu (Negri Sembilan)	120	Dr J. Miller	
Kuala Reman (Negri Sembilan)	84	Dr Pou	
Total	**696**	**08 doctors**	
Estate hospitals served by a visiting medical practitioner (Selangor)			
Batu	32	Dr Day	01
Batu Caves	30	Dr MacGregor	04
Bukit Hitam	36	Dr Day	04
Bukit Jalil	24	Dr Day	01
Castlefield	100	Dr Day	08
Hawthornden	32	Dr Day	02
Kent	96	Dr Haigh	04
Kepong	46	Dr MacGregor	04
Kinrara	45	Dr Day	03
New Amherst	23	Dr Day	03

Petaling	50	Dr Day	04
Ulu Buloh	40	Dr Day	02
Kudong	50	Dr Quaife	04
Batang Kail	50	Dr MacGregor	01
Broome	32	Dr MacGregor	02
Reko Association	42	NA	NA
Sungei Purun	10	NA	Na
Bukit Tunnggu	28	NA	NA
Dominion	36	Dr Day	01
Semenyih	40	Dr Day	02
Bhutan	20	Dr Macaulay	04
West Country	112	Dr Quaife	NA
Seafield	55	Dr Ritchie	12
Glenmarie	25	Dr Ritchie	12
Sungei Way	25	Dr Ritchie	08
Sungei Nebong	40	Dr Ritchie	Daily
Damansara	60	Dr Ritchie	12
Dusun Durian	21	Dr Guilfoyle	08
Brooklands	36	Dr Guilfoyle	08
Kuala Langat	30	Dr Guilfoyle	Daily
Sungei Buaia	34	Dr Guilfolye	08
Sungei Sedu	20	Dr Guilfolye	08
Tumbuk	15	Dr Guilfolye	01
Bukit Panjang	65	Dr Howard	Daily
Braunston	30	Dr Howard	08
Batang Berjuntai	61	Dr Howard	08
Rantau Panjang	60	Dr Howard	04
Raja Musa	40	Dr Howard	04
Merbad	14	Dr Howard	02

Kapar	90	Dr Hunter	Daily
Bukit Rajah	60	Dr Mc{herson	12
Padang Java	30	Dr McPherson	04
Highlands	44	Dr McPherson	08
Jugra Land and Rubber	40	Dr McPherson	03
Haron	50	Dr McPherson	08
Bukit Kamuning	NA	Dr McPherson	NA
Carey United	20	Dr McPherson	02
Sungei Rengam	50	Dr McPherson	08
Batu Unjor	36	Dr Young	08
Midlands	60	Dr Young	08
Rasak	24	Dr Young	08
Seaport	36	Dr Young	08
Bukit Rotan	124	Dr Glenny	Daily
Sungei Rambei	48	Dr Glenny	08
Raja Una	38	Dr Giddy	01
Bute	25	Dr Lionel Smith	02
Chee Who	20	Dr Miller	02
Total for Selangor	**2420**	**17 doctors**	
Estate hospitals served by a visiting medical practitioner (Perak)			
Bidor (Lower Perak)	24	Dr Ward	08
Bruseh (Lower Perak)	10	Dr Ward	04
Cluny (Lower Perak)	44	Dr Ward	04
Gedong (Lower Perak)	13	Dr Ward	04
Jong Landor (Lower Perak)	45	Dr Ward	04
Sungei Chinoh (Lower Perak)	30	Dr Ward	08
Tapah Rubber (Lower Perak)	33	Dr Ward	04
Trolak (Lower Perak)	30	Dr Ward	04

Arcadia (Lower Perak)	24	Dr Hancock	02
Ayer Tawah (Lower Perak)	12	Nil	Nil
Batak Rabit (Lower Perak)	46	Dr Giddy	04
Bernam Perak (Lower Perak)	20	Dr Giddy	04
Cicely (Lower Perak)	29	Dr Giddy	04
Jendarata (Lower Perak)	20	Dr Giddy	04
Melintang Coco (Lower Perak)	19	Dr Hancock	02
New Columbia (Lower Perak)	40	Dr Aiyer	04
Nova Scotia (Lower Perak)	58	Dr Giddy	04
Rubana (Lower Perak)	60	Dr Giddy	04
Sabrang (Lower Perak)	40	Dr Giddy	04
Selama and Somerset (Lower Perak)	50	Dr Giddy	04
Strathmashie (Lower Perak)	47	Dr Hancock	08
Walbrook (Lower Perak)	12	Dr Aiyer	04
Began Pasir Group (Lower Perak)	30	Dr Giddy	02
Allagar (Perak North)	46	Dr Dixon	08
Bagan Serai Joint (Perak North)	28	Dr McHutchison	08
Ban Poe Seng (Perak North)	36	Nil	Nil
Central Plus (Perak North)	60	Dr Scott	Daily
Changkat Salak (Perak North)	63	Dr Scott	Daily
Chersonese (Perak North)	89	Dr McHutchison	08
Elphil (Perak North)	30	Dr Scott	Daily
Gapis (Perak North)	48	Dr Dixon	08
Gedong (Perak North)	120	Dr McHutchison	08
Government Plantations (Perak North)	12	Dr McHutchison	04
Gula (Perak North)	120	Dr McHutchison	08
Hidden Streams (Perak North)	34	Dr Dixon	04
Kalumpang (Perak North)	32	Dr McHutchison	08
Kamuning (Perak North)	72	Dr Scott	Daily

Kota Tampan (Perak North)	16	Dr Hitchens	01
Matang Joint (Perak North)	30	Dr McHutchison	08
Merchiston Joint (Perak North)	24	Dr McHutchison	04
Perak River Valley (Perak North)	11	Dr Dixon	04
Selinsing Joint (Perak North)	25	Dr McHutchison	04
Sungei Bogak (Perak North)	36	Dr Murrayy	08
Sungei Krian (Perak North)	30	Nil	Nil
Sungei Kridda (Perak North)	54	Dr Scott	Daily
Sungei Limau (Perak North)	36	Dr Dixon	04
Tali Ayer (Perak North)	58	Dr Murray	04
Trong (Perak North)	44	Dr Dixon	08
Windsor (Perak North)	16	Dr McHutchison	04
Chemor Estate (Kinta)	42	Dr Hitchens	08
Chemor United (Kinta)	23	Dr Skae	08
Glenealy Estate (Kinta)	24	Dr Skae	01
Kinta Kellas (Kinta)	36	Dr Hitchens	04
Klebang Estate (Kinta)	18	Dr Hitchens	04
Kota Bharu Estate (Kinta)	38	Dr Hitchens	04
Sengat Estate (Kinta)	26	Dr Htichens	04
Strathisla Estate (Kinta)	60	Dr Skae	04
Total for Perak	**2076**	**10 doctors**	
Estate hospitals served by a visiting medical practitioner (Negri Sembilan)			
Ainsdale (Seremban District)	50	Dr Smith	08
Bataug Benar (Seremban District)	45	Dr Smith	04
Bukit Nanas (Seremban District)	40	Dr Smith	04
Kirby (Seremban District)	72	Dr Smith	08
Kubong (Seremban District)	74	Dr Smith	02
Kombok (Seremban District)	24	Dr Macaulay	08

Linsum (Seremban District)	50	Dr Macaulay	08
Martin (Seremban District)	24	Dr Smith	04
Majorie (Seremban District)	31	Dr Smith	04
New Labu (Seremban District)	28	Dr Smith	08
Panjam (Seremban District)	36	Dr Smith	04
Pantai (Seremban District)	20	Dr Smith	04
Perhentian Tinggi (Seremban District)	72	Dr Smith	08
Ribu (Seremban District)	24	Dr Macaulay	08
Seneway (Seremban District)	67	Dr Smith	12
Serembau (Seremban District)	100	Dr Macaulay	12
Sungei Mahang (Seremban District)	40	Dr Smith	04
Tampin Linggi (Seremban District)	34	Dr Macaulay	02
Terentang (Seremban District)	65	Dr Macaulay	08
Third Mile (Seremban District)	41	Dr Mirylees	08
Ulu Rantan (Seremban District)	80	Dr Macaulay	08
Ulu Sawah (Seremban District)	30	Dr Smith	08
Atherton (Port Dickson District)	100	Dr Mirylees	12
Bradwall (Port Dickson District)	47	Dr Smith	08
Chee Who (Port Dickson District)	20	Dr Miller	01
Jemimah (Port Dickson District)	100	Dr Mirylees	16
Jimah (Port Dickson District)	8	Dr Macaulay	12
Sagga (Port Dickson District)	60	Dr Smith	12
Silian (Port Dickson District)	42	Dr Smith	12
St. Leonards (Port Dickson District)	63	Dr Smith	12
Sua Manggis (Port Dickson District)	20	Dr Macaulay	02
Sungei Salak (Port Dickson District)	28	Dr Mirylees	08
United Sua Beutong (Port Dickson District)	30	Dr Macaulay	01
Chembong Pedas (Tampin District)	20	Dr Smith	04

Chimpul (Tampin District)	24	Dr Weir	04
Gan Kee (Tampin District)	12	Dr Rattray	01
Lobok China (Tampin District)	12	Dr Weir	01
Repah (Tampin District)	38	Dr Rattray	01
Total for Negri Sembilan	**1671**	**07 doctors**	
Estate hospitals served by a visiting medical practitioner (Pahang)			
Government Plantation, Kuala Tembeling (Kuala Lipis District)	26	Nil	Nil
Atbara (Kuantan)	14	Dr Peart	01
Jeram (Kuantan)	24	Dr Peart	01
Semambu (Kuantan)	20	Dr Peart	01
Ruby (Kuantan)	Nil	Dr Peart	01
Sungei Talam (Kuantan)	20	Dr Pou	01
Choong Heng (Kuantan)	30	Dr Peart	01
Cheroh (Raub District)	44	Dr Masters	01
Sungei Mas (Raub District)	12	Dr Masters	01
Karak (Raub District)	30	Dr Masters	01
Total for Pahang	**194**	**03**	
Total number of hospital beds provided by estates	**7057**	**45**	

Source: Federal Council, Federated Malay States, Reports, No.7. 9 April 1918: "From Chief Secretary to Government, FMS, to the Secretary to the Government of Madras. No.5521/15, 22 June 1916, pp.C39-42.

Table 19: Estate Workers and Land Acreage

State	No of large estates	No of small estates	Total	Acreage of large estates	Acreage of small estates	Total acreage	Estate labourers	Total population
Perak	463	459	922	396,654	22,451	417,105	52,721	79,681
Selangor	413	257	670	399,272	14,145	413,417	57,476	88,025
N.Sembilan	417	475	892	310,089	23,910	333,999	43,727	52,577
Pahang	197	424	621	198,567	21,343	219,910	10,733	13,120
Total	**1,490**	**1,615**	**3,105**	**1,304,582**	**81,819**	**1,386,431**	**164,697**	**233,403**

Note: Large estate: 100 acres and over, Small Estate: 25-100 acres,Total population: including dependents. Source: *Federated Malay States, Medical Report,* 1932, p. 4.

Table 20: Hospital Service and Health Conditions on Estates, British Malaya, 1934

Health Variables	Straits Settlements	Federated Malay States	Johore	Kedah	Kelantan
Indian estate population	19,185	105,607	18,802	17,679	1,071
Crude Death Rates (per 1,000)	5.89	6.73	6.97	8.06	11.20
Number of estate hospitals	26	129	36	11	6
Group hospitals	1	49	4	6	-
Number in charge of a resident Medical Officer	1	10	4	-	-

Source: *SSAR*, 1938. Vol 2. p. 65.

Annex A, Appendix 3: Tables in Chapter 4

Contents:

Table 21: Straits Settlements Population in 1924

Race	Total	Rural
Malay	260,710	200,831
Chinese	553,183	135,976
Indian	120,025	68,787
Eurasian	9,360	1,482
European	8,317	1,936
Others	9,537	1,936
Total	**960,952**	**410, 838**

Source: RAC.RG.5.3.B.210. F.2590.C.473H. "Paul F. Russell. The Straits Settlements Rural Sanitation Campaign. Reprinted from The Malayan Medical Journal. Vol IV No.3, pp. 79-83".

Table 22: Total Anthelmintic Treatments: Straits Settlements, 1925-8

Areas	1925 Survey	1926	1927	1928	Total
Campaign Malacca	70	22,194	1,949	-	24,213
Campaign Northern Settlement	25	-	30,566	2,101	32,692
District Health Centres	-	-	3,320	10,937	14,257
Government Hospitals and Dispensaries	49,473 (1), (2)	79,528	71,336	29,799	230,136
Estate coolies and schoolchildren	17,000 (2)	17,287	9,008	14,070	57,365
Malacca Agriculture Medical Board	18,000	23,056	18,174	-	59,230
Private Physicians	10,000 (2), (3)	12,000 (2), (3)	14,210 (3)	-	36,210
Quarantine Station	-	-	-	9,419	9,419
Total	**94,568**	**154,065**	**148,563**	**66,326**	**463,522**

(1) Pulau Jerejak and government hospitals only. Dispensaries not included
(2) Estimated Conservatively (3)Includes only Penang.
Source: *S.S.M.R.* 1928. Source: *SSMR*, 1928. "Annex N: Straits Settlements Rural Sanitation Survey and Campaign. Final Report and Tables. 1925-1928. p. 157

Table 23: Anthelmintic Treatments by Race in Straits Settlements Rural Sanitation Campaign, 1925-8

Race	1925	1926	1927	1928	Total No.	Percentage
Malays	48	17,906	19,081	892	37,927	66.6
Indians	14	1,652	7,217	941	9,824	17.3
Chinese	33	2,170	5,386	267	7,856	13.8
Eurasians	-	433	695	-	1,128	2.0
	-	6	42	1	49	0.1
Others	-	27	94	-	121	0.2
Total	95	22,194	32,515	2,101	56,905	100

Source: Annex N: Extracts from The Straits Settlements Rural Sanitation Survey and Campaign Final Report and Tables, 1925-1928. Table No 33, p. 153

Table 24: District Health Centre Statistics, 1926-1928

	Malacca	Northern Settlement	Singapore	Total
Health lectures	1,528	1,749	-	3,277
Attendance at Lectures	20,458	7,232	-	27,690
Anthelmintic Treatment	14,587	2,794	314	17,695
Other Treatments	3,237	20,194	3,110	26,541
Total Treatments	17,824	22,988	3,424	44,236
Attendance at Health Centres	4,055	4,438	1,533	10,026
Visits made by Health Sister or Nurse	14,452	5,721	6,911	27,084
Stools examined	4,647	139	-	5,386
Stools containing hookworm ova	3,999	338	-	4,337

Source: *SSMR*, 1928. "Annex N: Straits Settlements Rural Sanitation Survey and Campaign. Final Report and Tables. 1925-1928. p. 157

Table 25: Public Health Lectures by Staff of Straits Settlements Rural Sanitation Campaign, 1926-8

Race	Number of Lectures grouped according to language of lectures			Number of attendance grouped according to their race		
	Malacca	Northern Settlement	Totals	Malacca	Northern Settlement	Totals
Malay	326	414	740	19,003	34,102	43,105
Indian	75	94	169	7,243	3,764	11,007
Chinese	117	256	373	4,635	19,125	23,760
English	124	128	252	285	2,002	2,287
Total	**642**	**892**	**1,534**	**31,166**	**48,993**	**80,159**

Note: This table did not include the District Health Centres which gave lectures to a total of 3,227 people or the 110 shows given in 1927. Source:*SSMR*. 1928. "Annex N: Straits Settlements Rural Sanitation Survey and Campaign, Final Report and Tables, 1925-8. Table 39, p.156.

Annex A, Appendix 4: Tables in Chapter 5

Table 26: Total estimated death rates from 1918 Influenza in British Malaya

State	Estimated Deaths from influenza in 1918	Total Population (according to the 1921 census)	Percentage of Death
Straits Settlements (Singapore, Malacca Penang)	6,344	883,769	0.71
Selangor	5,285	401,009	1.31
Pahang	2,129	146,064	1.45
Negri Sembilan	5,114	178,762	2.86
Perak	6,056	599,055	1.01
Kedah & Perlis	5,028	378,645	1.32
Kelantan	Not Available	309,300	
Trengganu	Not Available	153,765	
Johore	2,758	282,234	0.97
British North Borneo	1,930	226,677	0.85
Brunei	Not Available[1]	25,451	
Total deaths from Influenza	**34,644**	**3,584,761**	**0.97**

[1] According to the British Resident's report, the protectorate had largely escaped the epidemic with only mild cases of infection among coolies in plantation estates. *Report for the State of Brunei for the year 1918*, p. 5.

Annex A, Appendix 5: Tables in Chapter 6

Table 27: Shops for sale of Prepared Opium:

State	No of opium shops	Adult Chinese Male population	Number of potential customers per shop
Singapore	423	159,531	305
Penang	188	62,369	332
Malacca	194	25,314	130
Labuan	7	632	90
Straits Settlements	**812**	**247,846**	**305**
Perak	123	129,080	1,049
Selangor	98	93,114	950
N Sembilan	53	46,083	869
Pahang	49	24,214	605
Federated Malay States	**314**	**292,491**	**931**
Johore	461	67,012	148
Kedah	49	40,017	816
Perlis	7	2,126	304
Kelantan	35	7,423	212
Trengganu	25	5,3231	209
Brunei	17	884	52

Source: British Malaya Opium Committee: Report of the Committee appointed 27 November 1923 (Singapore: Government Printer, 1924) p. A25.

Table 28: Opium Revenue of the Straits Settlements

Year	Net Total Opium Revenue	Total Colony Revenue	Percentage of Net Opium Revenue to Colony's Revenue	Total Expenditure of Colony
1919	13,874,322	34,108,464	40.7	34,901,233
1920	19,576,370	42,469,620	46.1	39,260,318
1921	14,749,892	39,545,735	37.4	35,430,898
1922	14,259,159	34,103,462	41.8	24,797,084
1923	14,521,471	33,316,014	43.6	26,717,777
1924	11,134,330	28,639,160	38.9	26,706,315
1925	12,548,464	53,850,960	23.3	57,593,959
1926	11,132,206	36,465,213	30.5	36,955,640
1927	12,872,968	37,602,080	34.0	39,253,272
1928	12,322,263	38,092,220	32.3	35,007,508
1929	8,276,919	54,888,290	15.1	35,711,997

Note: In 1925, $20 million were transferred from the Currency Commissioners' Guarantee Fund to the General Revenue. In 1929, $19 million were transferred from the Currency Commissioners Guarantee Fund to the General Revenue. Source: Taken from various tables from League of Nations: Commission of Enquiry into the Control of Opium in the Far East (Geneva, 1934) pp. 69-70.

Annex A, Appendix 6: Tables in Chapter 7

Table 29: Admissions to the Maternal Medical Mission, 1912-19.

Attendances	1912	1913	1914	1915	1917	1918	1919
In-patients:	51	62	84	78	140	170	203
Total attendances	5,302	4,532	5,324	5,440	4,009	3,189	3,521
Malay attendances	4,218	3,350	2,743	2,243	766	517	1,918
New cases, out patients:	-	-	3,268	-	1,779	1,249	1,296
Ophthalmic Diseases	284	244	279	179	131	48	67
Gynaecological Diseases	297	45	462	891	324	470	663
Malaria and complications	807	298	1,006	354	99	123	143
Dental extractions	NA	-	75 -		31	-	09
Operations under Chloroform/spinal anaesthesia	NA	826	86	46	20	06	19

Minor Operations	328	-	-	-	30	-	43
Vaccinations	-	-	-	33	36	17	17
Maternity Cases	-	-	-	-	63	83	102
Visits to Alai Dispensary	Na	188	-	1,402	48	-	-
Surgical Dressings	867	156	-	-	883	1,532	
Death Certificates	-	-	-	-	33 -	14	25
Still born infants	-	-	-	-	-	09	08
Spanish Influenza	-	-				185	-
Venereal	209	-	404	139			-
Beri-beri	145	-	183				-

Source: *S.S.M.R,* 1912-19

Table 30: Child Admissions into Singapore's Hospitals, 1928-32

Hospitals	1928			1929			1930			1932		
	A	Dis	Died	A	Dis	Died	A	Dis	Died	A	Dis	Died
General Hospital, Singapore	601	399	168	731	414	282	994	514	438	1,189	547	586
Kandang Kerbau Hospital, Singapore	442	259	183	469	307	161	335	235	100			
St. Andrew's Mission Hospital, Singapore	577	439	138	572	406	146	409	216	193	502	346	712
Total	1,620	1,907	489	1,772	1,127	589	1,738	965	731	1,691	893	742

A: Admitted, Dis: Discharged
Source: *SSAR*, 1928-32

Table 31: Women and Children's Dispensaries in the Straits Settlements

Hospitals in Straits Settlements	1928			1929		
	New Patients	Repetitions	Total	New Patients	Repetition	Total
Women and Children's Dispensary, Kandang Kerbau, Singapore	15,495	19,727	35,222	13,800	17,431	31,231
Women's and Children's Dispensary, Penang	6,659	10,683	17,342	7,302	15,848	23,150
St Andrew's Mission Dispensary	3,617	7,562	11,179	3,621	7,934	11,555
St David's Mission Dispensary	-	-	6,620	3,373	6,783	10,056
Total	**25,711**	**39,972**	**70,363**	**28,096**	**47,996**	**75,992**

	1931			1932		
	New Patients	**Repetition**	**Total**	**New**	**Repetition**	**Total**
Women and Children's Dispensary, Kandang Kerbau	15,719	20,095	35,814	13,695	36,400	50,095
Women's and Children's Dispensary, Penang	1,776	3,821	5,597	9,824	10,118	19,942
St Andrew's Mission Dispensary	4,385	5,616	10,001	**5,893**	5,433	10,789
St David's Mission Dispensary	4,051	13,441	17,492	**5,893**	3,176	6,259
Total	33,792	60,248	90,478	35,305	55,127	87,085

Source: *SSMR*, 1928-32.

Table 32. Deliveries in the Hospitals of the Straits Settlements

Hospital	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938	Total
Maternity Ward, General Hospital, Singapore	874	885	1,063	1,007	1,095	1,135	1,302	1,585	1,014	549*	551	10,790
Free, Maternity Hospital, Kandang Kerbau, Singapore	1,304	1,606	2,099	1,955	2,336	2,303	2,579	3,507	4,717	5,214	5,551	33,171
St Andrew's Mission Hospital	255	261	295	261	302	300	309	328	431	489	420	3,051
Maternity Ward, Kwong Wai Siu Hospital Singapore	454	458	387	288	241	196	221	279	389	615	812	4,340
King Edward VII Maternity Hospital, Penang	966	1,102	1,469	1,260	1,391	1,364	1,480	1,768	1,996	2,073	2,506	16,375
Maternity Wards in Province Wellesley and Lumut Hospitals	55	105	107	96	147	156	171	144	183	275	318	1,627
St David's Mission Hospital, Malacca	90	134	326	320	323	185	202	337	506	812	1,048	4,283
Maternity Wards in Malacca and other district hospitals	69	90	155	148	179	-	103	152	87	-	-	983
Total	4,067	4,613	5804	5,335	6,016	5,639	6,367	8,100	9,413	10,027	11,206	74,894

*3rd Class patients transferred to Kandang Kerbau Hospital from Singapore General Hospital from 1937. *S.S.A.R.*, Compilation of data between 1928-38.
Source: Compilation of *S.S.A.R*,. 1928-38.

Annex B: Petitions and information pamphlets by Health Lobbies

Appendix 1: Correspondence Regarding the Establishment of a Medical School in Singapore

Appendix 2: Tolerated Brothels within the British Empire (Association for Moral and Social Hygiene)

Appendix 1: Correspondence Regarding the Establishment of a Medical School in Singapore

No.14

Friday 17 March 1905

Correspondence Regarding the Establishment of a Medical School in Singapore

Petition from Certain Inhabitants of Singapore in Governor Sir John Anderson. K.CM.G

1. Your petitioners desire to bring to Your Excellency's notice the desirability of establishing and maintaining in Singapore a medical school where residents in this colony and the Federated Malay States may be trained so that they may be able to enter the Government service as Assistant Surgeons or practice their profession as general practitioners.
2. The establishment of such a school was first advocated by Dr Simon, C.M.G., late Principal Civil Medical Officer, and has considerable support in other quarters. The Commissioners appointed to enquire into the system of English Education in the Colony advert to the scheme in paragraph 30 of their report in 1902, and after pointing to the conflicting nature of the evidence upon the subject made the following statement: "The Commission much regret the evidence before them as they feel the great advantage which would accrue to the Colony and the Native States by the introduction of a system of training which would produce out of local material, men better qualified to supply the demand for Assistant Surgeons and general practitioners among the native population and poorer inhabitants. The introduction of this would pave the way to limiting practice to men who had attained the necessary qualifications.
3. Your petitioners are convinced that there are no inseparable difficulties in carrying out a scheme for the establishment of such a Medical School and they are much impressed by the great practical good which would result from it. A large portion of the native population are unable or unwilling either on the grounds of expense or ignorant prejudice to avail themselves of the service of European practitioners and are accordingly thrown back upon persons with little or no medical training with results very far from satisfactory.
4. The importance of a general comprehension of proper sanitary conditions and habits is of paramount importance to any country and your petitioners feel that no measure can so successful diffuse this understanding as the provision of a proper supply of trained medical men who are in racial sympathy with those whom they attend.

Your petitioners therefore humbly pray that Your Excellency will give this matter your earnest consideration and take steps to get a proper scheme framed for the establishment of a Medical School in Singapore

Sd. TAN JAIK KIM & Others.

Dated the 8th Day of September, 1904.

No.13

Friday 3rd March 1905

Report on the Select Committee appointed to consider and report upon the Provisions of the Poisons Bill

1. We met on the 25th November 1904, and heard the evidence of Mr Barnes, Secretary for Chinese Affairs who produced and put in a copy of a Resolution of the Chinese Advisory Board on the subject of the Bill. We also heard the evidence of Mr Burgess, Government Analyst, who was requested to draw up an amended schedule of Poisons for consideration, and of Dr. Lim Boon Keng.
2. On the 29th November, 1904, we personally visited and inspect a number of Chinese and Indian medicine shops in the town.
3. On the 26th January, we met again and received and discussed an amended list of poisons and a memorandum thereon put in by Mr Burgess. Dr McDowell was also called and gave his views generally on the questions raised.
4. We then went through the clauses of the Bill and resolved to recommend the amendments appearing on the print of the Bill attached to this report and marked C.
5. We have settled the Bill on the assumption that it shall apply to all vendors of poisons in the Colony, that being the form in force in Ceylon, and the Principal Civil Medical Officer being strongly of opinion that if it were limited in its scope is not too wide we have amended Section 14 (h) so as to allow the Governor in Council to absolutely exempt from the operation of the Ordinance persons or classes of persons.
6. Our view is that the primary intention of the Bill is to regulate the sale of poisons by chemists and druggist, but beside them wholesale merchants selling such articles as hydrochloric acid (largely used in soldering in pineapple manufactories and cyanides used in gold mining and also dealers in photographic materials will require to be licensed and to comply with the provisions of the Ordinance. The Principal Civil Medical Officer argues that by subjecting these persons to the Ordinance as complete a means as possible of tracing poison in criminal cases will be furnished. It must, however be borne in mind that such a measure would not bring within its scope that large source of poison which nature provides on every side of us, the datura plant, nor would it afford any means of tracing death and sickness caused by bamboo hairs or powdered glass which are common modes by which sickness or death are wilfully produced, nor would it afford any means of tracing poison abstracted from the custody of licensed vendors, nor poison after it has been sold. Since then the system provided must necessarily be incomplete and since no complaints have reached us of poisoning from these sources, we doubt whether the advantage to be gained from licensing wholesale merchants selling poisons for commercial purposes and vendors of photographic material will compensate for the inconvenience that such licensing will occasion.
7. The important object to bee gained by the Bill are that persons who dispense European poisons shall be licensed after a proper test of their qualification and that they should keep books in English showing the mode in which they have dispensed or sold poisons.
8. So far as we have been able to ascertain, poisons are but little used by Chinese chemists, who are of course dispense by far the largest amount of drugs in the Colony, and the poisons used by them are mostly of a mild character and are used chiefly for external use. It would be impossible for a Licensing Officer to satisfy himself that a Chinese chemist applying for a licence is of "sufficient skill and habitual caution," and accordingly we have deleted these words from Section 6, in order that licences may be granted after enquires as to standing and reputation have

proved satisfactory. The Chinese shopkeepers whom we visited showed no reluctance to keeping books relating to poisons in Chinese and we desire to express an opinion that it is undesirable to compel the shopkeepers so long as they deal only in Chinese poisons to keep their books in English, but this reasons we have taken out the Schedule prescribing the form of book to be kept in licensed persons leaving it to the Governor in Council to provide for this by rule.

9. The Schedule which we have annexed to the Bill is prepared for the Government Analyst and approved by the Principal Civil Medical Officer. We add their ntoes as to this Schedule. The alteration in Section 4 alluded to above will enable the Governor in Council to exclude from the Ordinance persons licensed to sell opium or bhang who are dealth with under separate Ordinace.

Select Committee:
W.R.Collyer (Attorney General)
W.L. Napier
Tan Jiak Kim

Appendix 2: Tolerated Brothels within the British Empire (Association for Moral and Social Hygiene)

Women Library. Ref: 3/AMS.6.3.1. Malaya 1925-55

Tolerated Brothels within the British Empire

The New Situation in the Federated Malay States

The Association for Moral and Social Hygiene is asking for support for the following resolution:

This Committee of the.....has heard with deep regret that the Secretary of State for the Colonies has sanctioned an amendment of the law in the Federated Malay States concerning the compulsory examination of certain prostitutes which is, in effect, a reinforcement of the existing system under which a very large number of brothels are officially recognised by the British Government.

This Committee regards this new legislation as a further attempt to secure healthy women for the tolerated houses and therefore entirely contrary to the recommendations of the Colonial Office Advisory Committee on Social Hygiene, which recommended that the Government 'should frame its policy now with a view of making possible at the earliest practicable date the suppression of all brothels whenever their existence is discovered.

This Committee urges the British Government to call together again the Advisory Committee and to put before it all proposals dealing with prostitution which are being or may be made in the Federated Malay States, the Straits Settlements, Hong Kong, Malta and Cyprus.

This resolution is part of the campaign which the A.M.S.H initiated many years ago for the complete abolition within the British Crown Colonies of the system of State regulation of vice. In order to make the situation clear to those who may only be in touch with the more recent developments it is necessary to state briefly, the events which have led to the present state of affairs.

Hong Kong, Singapore (Straits Settlements) and Federated Malay States

The laws dealing with prostitution and brothel-keeping are, for all practical purposes, identical in these three Crown Colonies. The Federated Malay States are scarcely distinguishable from the Straits Settlements, except for some technicalities of local government; and this has an important bearing on the above resolution, *as any legislative action allowed by the British Government in the Federated Malay States is likely to be also enacted in Singapore and Hong Kong.*

The Association for Moral and Social Hygiene has since 1878, continuously kept in touch with social hygiene matters in these colonies and from time to time, taken such action as seemed helpful. It was due to AMSH efforts that the Contagious Diseases Acts were repealed in Hong Kong, Singapore and the Federated Malay Sttes in 1887. But we were not equally successful in securing the abolition of recognised brothels. The British Government of that date, realising that public opinion at home would not tolerate continuance of the Government enforcing the

medical examination of recognised prostitutes, enacted legislation in these three colonies whereby instead of the Government itself compelling such examinations, the Government compelled the brothels keepers to see that the women in the recognised (or tolerated) houses were regularly examined by private practitioners. It was a distinction without much difference, but it enabled the Home Government to disclaim direct responsibility for the compulsory examinations.

In 1914, the scandal of the great brothel areas allowed by the British authorities to exist in these colonies and the resulting traffic in young Chinese women reach such a pitch that the AMSH first submitted privately to the Colonial Secretary, and later published, full and documented reports on the conditions in Hong Kong and Singapore, but nothing was done. The War intervened, but in 1918 we raised the matter again with the Government and began a public propaganda for the abolition of all State regulation of vice within the British Empire.

Straits Settlements Demands Licensed Houses

In 1923, a special *medical* committee in Singapore issued a report demanding the immediate re-enactment of a most drastic form of Contagious Disease Act, including the licensing and weekly medical examination of all prostitutes (any women who had once had intercourse for gain was to be registered as a prostitute), the licensing by Government of all brothels and the appointment of a Government "Controller" of Brothels.

The Medical Committee also demanded that diseased prostitutes should be notified, be driven at once out of the brothels, have their license withdrawn and cases practising prostitution.

One medical man on the Committee said plainly, in an appendix published with the Report, that all the prostitute community in Singapore, if scientifically examined, would be found to be diseased. He also said

"In Singapore, there is a need for a prostitute community."

When this Report from the Singapore Medical Committee-backed by the Local Legislature of the Straits Settlements-came to the British Government, the AMSH published two critical examinations of these reactionary proposals, made the facts known and gave the then Bishop of Singapore (Dr Ferguson-Davie) and a local Social Service Committee every assistance it could in the fight against the proposals of the Medical Committee.

The AMSH ultimately decided to ask the Colonial Office to appoint an Advisory Committee on "Social Hygiene," which would represent the best available modern medical opinion and also certain social and administrative aspects. The National Council for Combating Venereal Diseases (now the British Social Hygiene Council) supported the AMSH in this request and eventually the Advisory Committee was set up. Its Report (CMD. 2501) is now well-known and was a complete vindication of Abolitionist principles at all points. It recommends inter alia:
"at the earliest practicable date, the suppression of all brothels, whenever their existence is discovered."

This report by the Colonial Office Advisory Committee was not acceptable to those who had demanded more licensing of brothels, more medical examination of prostitutes and the driving out of all diseased women (ie. All the present prostitute community) and their replacement by healthy women.

An extended scheme for the free treatment of venereal disease was put into operation, but no action was taken with regard to brothels, except to reduce somewhat the illumination of the vice areas.

The AMSH had some questions asked in Parliament in 1926 but it became apparent that the suppression of recognised brothels was not making any headway. The Special Medical Committee in Singapore obviously did not intend to be so easily defeated. It wanted licensed houses and women medically examined every week and presumably it meant to have them, if possible when the agitation died down.

Back to the Regulation System.

And now a move has been made! Not in Singapore or Hong Kong, places to which public attention has been given, but quietly in the Federated Malay States to which attention has not bee drawn, and concerning which few people are quite certain whether it is a British Crown Colony or not.

What that move is may be gathered from the following question in Parliament which Lady Astor asked on behalf of the AMMSH on June 29th:

FEDERATED MALAY STATES (WOMEN & GIRLS)-Viscountess Astor asked the Secretary of State for the Colonies whether, seeing that the Government has approved an amendment to the Federated Malay States Women and Girls Protection Enactment, whereby a prostitute suspected of being venereally diseased may be compulsorily examined, he will explained the reason for authorising this amendment , which appears to be inconsistent with the general principles laid down in the 1925 Report of the Advisory Committee to the Colonial Office on Singapore; and whether he will call this Committee together again to consider this amendment ad others of a like character and report upon them?

Mr Amery: The object of the amendment is to prevent brothel keepers from evading the provisions of the law which prohibits their permitting a woman suffering from contagious disease to remain in the brothel. There was previously no power to order the medical examination of a prostitute. Thus the object of the law has been defeated by brothel keepers instigating prostitutes to object to medical examination. There is no question of any general compulsory and periodical examination. The amendment has received my approval and I do not consider it necessary to call the former committee together again to consider it.

Read carefully this reply by the Colonial Secretary. Who would suppose that his own Advisory Committee of Naval, Military and Departmental medical experts had recommended the suppression of all brothels "at the earliest practicable date" in these British settlements? The new legislation unobtrusively passed in the Federated Malay States shows clearly from where it originates. If this passes unchallenged and unexposed then Abolitionist work in the Far Eastern Colonies is undone. It will be almost as if the Advisory Committee had never existed. The Advisory Committee will have suffered defeat on its "First Report," and the Special Medical Committee of Singapore, the Committee which wants the full C.D. Acts back again, will win an important victory.

The AMSH begs that all societies, remembering the deep disgrace to the British Empire of the traffic in Chinese and other Eastern girls which ensues from existing conditions and remembering, too, that this Naval Station continuously produces the highest venereal rate in the whole British Navy, will join with it in opposing the new move by the Federated Malay States.

Please bring the Resolution at the beginning of this paper before your Committees as soon as possible and send it, when adopted, to:

The Secretary of State for the Colonies
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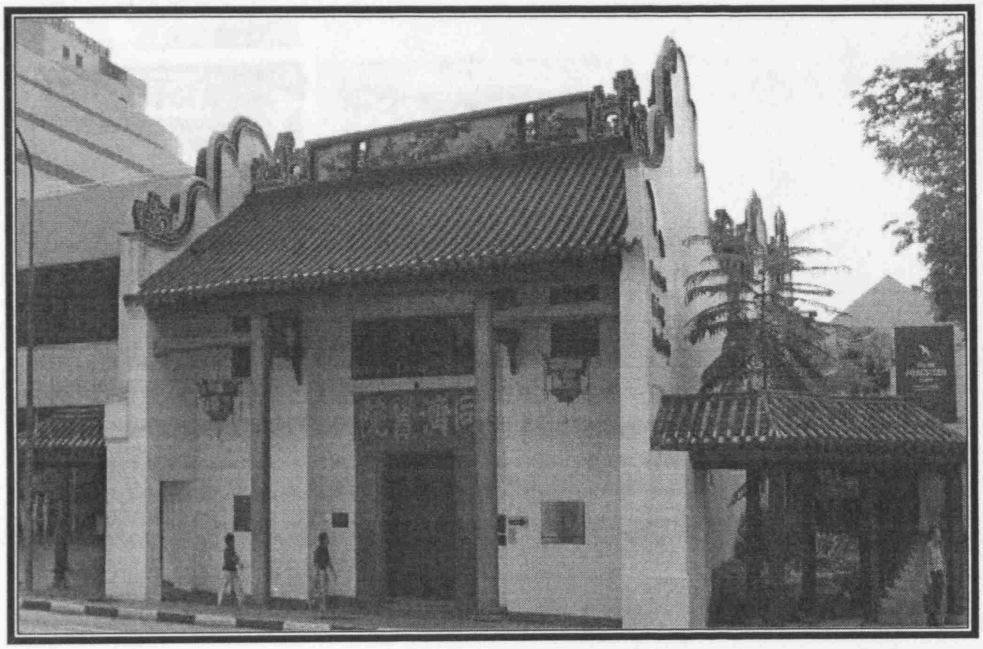
Annex C: List of illustrations

C.1Map of British Malaya

C.2. Thong Chai Medical Hall, Singapore



C.3 Advertisement of Eng Aun Tong Medical Hall in 1920 by Aw Boon Haw and Aw Boon Par.

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C.8.1.Crowds attending an anti-hookworm treatment demonstration by the International Health Board (RAC)

C.8.2. Public Health Education Pamphlets distributed by the International Health Board during the Straits Settlements Sanitation Campaign (RAC)

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